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Safety as Care:

Exploring Mental Health Care in the Criminal Justice Context

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by

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Dedication

For Britt.

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Abstract

Safety as Care:

Exploring Mental Health Care in the Criminal Justice Context

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Persons with serious mental illness (PSMI) are consistently over-represented in the criminal justice system. In an effort to reduce justice involvement and recidivism among PSMI, criminal justice and mental health systems have developed numerous intervention-related programs that emphasize increased access to psychiatric treatment and diversion. In practice, however, various institutional and organizational discrepancies between the two systems constrain the autonomy and decision-making power of the mental health professionals who work in these settings. I conceptualize these mental health professionals as boundary role incumbents, and I am particularly interested in exploring their attempts to reconcile the limitations placed on their service ideals. Furthermore, I am interested in exploring the collaborative and practical implications of this dynamics. The data for this project stem from a series of ethnographic observations with mental health professionals

working in various justice-oriented contexts. In particular, this study focuses on mental health professionals who provide community-based crisis intervention services, jail-based mental health services, and community-based mental health services for adults on probation and parole. The programs in this study are located in a single Central Texas county, and represent a range of justice-mental health service models in the area. The ethnographic data, consisting of extensive fieldnotes, capture the work-related experiences of the mental health professionals operating in their respective fields. The analyses in this dissertation explore the ethnographic data within the context of each site, and I also present an overarching theme that considers the implications of the findings across all contexts. I find that mental health boundary spanners reconcile the tensions between their occupational constraints and service ideals by conceptualizing their work as 'planting a seed' among the individuals they serve, particularly with the hope that a pattern of sustained engagement with other direct services will emerge. However, given mental health boundary spanners' loss of professional autonomy and the limited recourse available to the individuals they serve, I suggest that 'planting a seed' is the practical ceiling of these justice-mental health interventions, while 'people processing' is their norm. These findings contribute to contemporary discussions that contextualize the function and purpose of criminal justice and mental health reforms.

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Chapter 1: Planting a Seed

Persons with serious mental illness (PSMI)[1] are consistently over-represented in the criminal justice system (Bureau of Justice Statistics 2006; Steadman et al. 2009; Teplin 1990). In an effort to reduce justice involvement and recidivism among PSMI, criminal justice and mental health systems have developed numerous intervention-related policies and practices that emphasize increased access to psychiatric treatment and diversion (Council of State Governments 2002; Lamb, Weinberger, and Gross 2004; Munetz and Griffin 2006). These intervention programs target multiple points of justice system processing, including pre-arrest diversion, post-arrest/pre-trial diversion, mental health courts, access to psychiatric treatment during incarceration, re-entry planning, and community-based support. In practice, however, these mental health services are often constrained by external influences and conflicting procedures between the two systems (Draine, Wilson, Pogorzelski 2007; Steadman 1992). These institutional and organizational constraints represent a direct threat to autonomy and decision-making powers of the mental health professionals who work in these settings (Draine et al. 2007; Steadman 1992). And yet, the current literature is not at all clear as to whether these mental health professionals attempt to reconcile the tensions in their work, or how these dynamics might otherwise influence their perception of the services they provide. As such, this research is principally motivated by the professional experience of providing mental health services in various justice-oriented contexts.

[1] For more information about the use of this terms and other related terminology, see: Glossary.

This research has four main conceptual threads. I begin with reference to the organizational literature, and conceptualize the mental health professionals who work in these settings as organizational boundary spanners (Aldrich and Herker 1977; Steadman 1992). I am particularly interested in exploring the occupational duties and professional autonomy of mental health boundary spanners. Next, I consider the work-related tensions that manifest for mental health boundary spanners, particularly as their service ideals conflict with various organizational constraints. Then, I borrow from institutional and organizational theory in order to explore the pressures of conflicting institutional logics (Chiarello 2015; Thornton and Ocasio 2008) and the process of decoupling (Lipsky 2010; Meyer and Rowan 1977). Specifically, I examine mental health boundary spanners' attempts to reconcile the limitations to their service ideals. Finally, as mental health boundary spanners' work becomes increasingly entangled with justice-oriented objectives, I reflect on the collaborative implications of dual loyalty (Bloche 1999) and the practical implications of perceived liability and limited recourse (Scheid 2000).

The data for this project stem from a series of ethnographic observations with mental health professionals working in various justice-oriented contexts. In particular, this study focuses on mental health professionals who provide community-based crisis intervention services, jail-based mental health services, and community-based mental health services for adults on probation and parole. The three specific programs in this study are all located in a single Central Texas county, and represent a range of justice-mental health interventions and service models in the area. The ethnographic data, consisting of extensive fieldnotes, capture the work-related experiences of the mental health

professionals operating in their respective fields. The analyses in this dissertation explore the ethnographic data within the context of each site. I present core ethnographic scenes and shorter vignettes to illustrate the professional experience of providing mental health services in justice-oriented contexts. In addition to presenting the thematic findings, I also present an overarching research argument that considers the findings across all contexts.

Across various justice-oriented contexts, mental health boundary spanners reconcile the tensions between their occupational constraints and service ideals by conceptualizing their work as 'planting a seed' among the individuals they serve, particularly with the hope that a pattern of sustained engagement with other direct services will emerge. However, in my analysis of the ethnographic data across each of the research sites in this study, I suggest 'planting a seed' is the practical ceiling of these cross-system interventions. Instead of providing transformational mental health care that reduces justice involvement and recidivism, the mental health boundary spanners perceive the organizational and institutional function of their services in 'people processing' terms, shifting individuals when possible from one system to the other (Fisher and Drake 2007; Hasenfeld 1972). In the crisis outreach context, mental health boundary spanners are particularly frustrated with the lack of recourse available to individuals they serve. Similarly, in the jail setting, mental health boundary spanners struggle with the inevitability of harm caused by the environment in which they operate. And finally, in the context of community-based justice supervision, mental health boundary spanners describe the function of their work as, "Sweeping a flood with a broom."

Recent efforts to reform the criminal justice system have resulted in new practices in policing, prosecution, corrections, and other community supervision programs. Despite these changes, many scholars remain skeptical of the implications and overall consequences of procedural justice reform (Bell 2017). For instance, some scholars suggest reforms actually serve to reinforce the legitimacy of police and the power of the state (Engel, McManus, and Isaza 2020; Gorz 1968). Other scholars find they entrench the production of inequality (Brayne and Christin 2020). This research sheds new light on the recent proliferation of justice-mental health reforms. The development of connections to mental health care is a noble – if not necessary – criminal justice reform (Fisher, Silver, and Wolff 2006). However, as this research shows, such efforts may do more to change the provision of mental health care than the actual systems of justice processing.

RESEARCH MOTIVATIONS

Mental Illness in the Criminal Justice System

Contemporary reports show disproportionate rates of mental illness across justice-involved populations (Bureau of Justice Statistics 2006; Steadman et al. 2009; Teplin 1990). For instance, compared to the prevalence of serious mental illness in the general population of adults in the U.S. (4.1% overall), studies show the prevalence of serious mental illness among jail inmates is disproportionately high (14.5% daily average among men, and 31.0% daily average among women) even after controlling for demographic differences and adjudication status (Steadman et al. 2009). The prevalence of serious mental illness among prison inmates is also disproportionately high (Bureau of Justice Statistics 2006; Diamond et al. 2001).

Underlying the prevalence of mental illness among incarcerated populations, research evidence suggests justice-involved individuals with serious mental illness have a substantially heightened risk of recidivism (Baillargeon et al. 2009; Bonta, Law, and Hanson 1998). For instance, a study of 2006 Texas prison data finds, "Inmates with major psychiatric disorders were far more likely to have had previous incarcerations compared with inmates without a serious mental illness" (Baillargeon et al. 2009:105). Another study of 2004 California prison data finds parolees with serious mental illness are roughly twice as likely to return to prison within one year of release compared to their non-disordered counterparts (Eno Louden and Skeem 2011). Specifically, the results show, "Parolees with mental disorders commit a disproportionate number of technical violations, often for failing to attend psychiatric treatment" (Eno Louden and Skeem 2011:7). These patterns illustrate a distinct, if not enduring, cycle of justice involvement for persons with serious mental illness[2].

System Functions in Flux

Researchers and advocates argue these dynamics have serious implications for the criminal justice system. Empirically speaking, many of the largest county jails in the United States are also some of the largest mental health care institutions in the United States (Torrey 1995; Torrey et al. 2010). According to the *Criminal Justice and Mental Health Consensus Project*, which was first published in 2002, "The current situation not only

[2] In an attempt to explain the prevalence of mental illness in the justice system, most scholars point to two competing perspectives. For a review of this debate, see: Appendix 1: "Criminality vs. Criminalization."

exacts a significant toll on the lives of people with mental illness, their families, and the community in general, it also threatens to overwhelm the criminal justice system" (Council of State Governments 2002:6). Indeed, scholars suggest the criminal justice system is not designed to meet the treatment needs of people with serious mental illness. As Fisher and Drake contend, "The transformation of these settings into major purveyors of mental health treatment, and for some persons, their only source of mental health care, seriously distorts the function of the justice system" (Fisher and Drake 2007:547).

In an effort to address these issues, criminal justice and mental health systems at the local and state level have developed numerous cross-system interventions (Council of State Governments 2002). These intervention-related policies and practices are often characterized as part of the "Sequential Intercept Model," which outlines targeted mental health services at each level of justice system involvement (Munetz and Griffin 2006). Strategic points of intervention include pre-arrest diversion, post-arrest/pre-trial diversion, mental health courts, access to psychiatric treatment during incarceration, re-entry planning, and community-based support (Munetz and Griffin 2006). Munetz and Griffin introduce several intervention-related objectives, including, "Engaging individuals in treatment as soon as possible, minimizing time spent moving through the criminal justice system, linking individuals to community treatment upon release, and decreasing the rate of return to the criminal justice system" (2006:545). The overall aim is to ensure that justice-involved individuals with serious mental illness are in a position to receive targeted mental health services – even in instances when up-front diversion from the criminal justice

system is not a viable alternative (Draine and Herman 2007; Munetz and Griffin 2006; Lamb et al. 2004).

Tasks Versus Tools

In terms of effectively reducing justice involvement and recidivism among persons with serious mental illness, contemporary reviews find the most successful justice-mental health interventions rely on a combination of treatment, diversion, and additional supervision and social support (Barrenger and Canada 2014). Importantly, these programs address individual-level and environmental risk factors beyond psychiatric needs (Osher, Steadman, and Barr 2003). This approach is based, in part, on research evidence that suggests untreated mental illness is not directly associated with justice involvement and recidivism (Bonta et al. 1998; Draine et al. 2002; Skeem, Manchak, and Peterson 2011)[3]. As such, scholars generally recognize that local systems must develop comprehensive and long-term solutions by re-conceptualizing justice involvement among persons with serious mental illness and implementing collaborative programs across the full range of available justice-mental health intercepts (Fisher et al. 2006; Lamb and Weinberger 2013; Steadman, Morrissey, and Parker 2016).

Despite the ideals, many programs rely on a rather limited conceptualization of justice involvement among persons with serious mental illness. The underlying assumption

[3] In concise terms, "Severe mental illness itself, without other factors, does not lead to offending in most cases" (Skeem et al. 2011:90). For further review, see: Appendix 2: "The Role of Psychiatric Treatment in Context."

of this approach is that the risk of justice involvement and recidivism can be reduced strictly through increased access to mental health treatment (Draine et al. 2007:160; Lamb et al. 2004). In practice, such programs tend to focus on shifting people deemed worthy of treatment out of the criminal justice system and into the mental health system (Draine et al. 2002; Draine et al. 2007). In effect, a substantial number of individuals are excluded from receiving comprehensive services and support, as they are routinely screened out of the select treatment and diversion programs (Draine et al. 2007; Fisher and Drake 2007; Lamb and Weinberger 2013). Although jails can be expected to provide 'adequate medical care' (Estelle v. Gamble 1976), Steadman and colleagues posit, "It may be setting an impossible standard for jails (and other criminal justice agencies) to attempt long-term treatment impacts with rapid turnover, strained budgets, and a workforce whose primary goal is safety and security" (Steadman et al. 2016:17).

By emphasizing psychiatric treatment and diversion for relatively few individuals, these programs and policies end up placing an undue strain on the narrow treatment practices inside correctional facilities and beyond (Barrenger and Draine 2013; Steadman et al. 2016). In particular, these strains exacerbate many of the acute occupational challenges for front-line mental health service providers. According to Draine and colleagues (Draine et al. 2007:170):

> Making decisions about appropriateness for treatment is a routine part of most mental health services. But, within the context of the criminal justice system, decisions regarding the allocation of mental health services are not driven by objective assessments of the severity of a person's illness or services needs. We contend that within this service context decisions about eligibility for these treatment services have become entangled with informal assessments of the

person's guilt, culpability, and competence as well as security control factors like population management.

These issues remain a key part of the professional experience for mental health service providers, particularly as their work becomes increasingly 'entangled' with justice-oriented objectives (Draine et al. 2007; Lamb and Weinberger 2013). The current literature, however, is not at all clear as to whether mental health service providers attempt to reconcile the tensions in their work, or how these dynamics might otherwise influence their professional experience and their own sense of the structural recourse available to the individuals they serve. As such, this research is principally motivated by the professional experience of providing mental health services in various justice-oriented contexts.

RESEARCH QUESTIONS

Organizational Roles and Professional Prerogatives

In 1992, Steadman applied the concept of 'boundary roles' to the interface of criminal justice and mental health systems (Steadman 1992). Citing core organizational literature, Steadman notes that all organizations have boundaries and exist in an environment of other organizations (Aldrich and Herker 1977; Shrum 1990; Steadman 1992). Moreover, these organizational boundaries and their boundary roles serve to define an organization's formal authority. In context, Steadman contends, "Whatever two organizations in the mental health and criminal justice systems may be the focus, there are positions at their boundaries whose incumbents must regularly negotiate exchanges of many types between the two organizations" (Steadman 1992:77). Steadman gives multiple examples of boundary spanning positions, including mental health professionals who work

in direct coordination with courts, jails, and probation offices (Steadman 1992:79). Given the recent proliferation of justice-mental health interventions, I conceptualize mental health professionals as boundary role incumbents – or boundary spanners – in these particular settings. Following Steadman's approach, I explore how their roles are formally defined or otherwise influenced by organizational boundaries. Specifically, I ask, to what degree do organizational boundaries structure their occupational duties, or 'tasks'?

It is also necessary to characterize the repeated reference to mental health professionals and service providers. Generally, the term 'mental health professional' includes psychiatrists, psychologists, social workers, and nurse practitioners. In justice-mental health settings (and beyond), a majority of mental health services are provided by social workers and nurse practitioners (Scheid 2000). Although social workers and nurse practitioners have less professional power and recognition relative to their counterparts, they are nonetheless expected to produce service outcomes consistent with their systems of practice (Scheid 2000:703). In one approach to researching occupations in the field of mental health, Scheid examines the commodification of mental health care and its effect on the work of mental health service providers (Scheid 2000). Scheid focuses on the ethical dilemma presented to mental health professionals by a certain 'managed care' framework. In particular, Scheid notes, "(Mental health professionals) struggle to defend established treatment practices against organizational demands for cost containment and performance-based outcomes" (Scheid 2000:704). Here, following Scheid's approach, I examine the 'professional prerogatives' of mental health boundary spanners. Specifically, I ask, to what degree do they have autonomy and decision-making power within their professional roles?

Tensions between Tasks and Tools

Conceptually, Aldrich and Herker suggest that organizations tend to yield power – particularly in the form of discretion – to incumbents of the boundary role (1977:226). Steadman, however, cautiously describes the utility of this discretion in the justice-mental health context. Specifically, Steadman notes that discrepancies in the prevailing rules, regulations, and laws between each system can severely restrict the performance of mental health boundary spanners (Steadman 1992:78). Whereas mental health systems are guided by individualized care and person-centered treatment, criminal justice systems are guided by public safety, security, and individual accountability (Draine et al. 2007:170; Munetz and Teller 2004). Notwithstanding the discretion associated with the boundary role, these institutional and organizational discrepancies represent a direct threat to the professional prerogative of mental health boundary spanners.

Other scholars have explored similar dynamics in separate contexts. For instance, Lipsky (2010) examines policy conflict from the perspective of public service professionals. According to Lipsky, these 'street-level bureaucrats' have considerable discretion to allocate services but very little – if any – determination when it comes to defining their own objectives (Lipsky 2010:82). Lipsky argues the problem presented by street-level bureaucracy is an impossible one. He writes, "Street-level bureaucrats cannot do the job according to ideal conceptions of the practice because of the limitations of the work structure" (Lipsky 2010:xvii). In another study, Heimer and Staffen (1998) analyze the production of responsibility among parents with children in neonatal intensive care. They find, in part, "We cannot fully understand the process by which responsibility is

assigned and embraced or shrugged off unless we look closely at organizational influences and the interfaces between organizations" (Heimer and Staffen 1998:328). This organizational dynamic presents the following paradox: although taking responsibility means exercising a strict level of agency, we must also recognize the limitations on people's capacity to act independently of bureaucratic routines (Heimer and Staffen 1998:368).

Generally, mental health professionals focus on improved client functioning, and concern themselves with the quality and appropriateness of the services they provide (Scheid 2000:703). These professional standards, however, may be less compatible in specific justice-oriented contexts. For instance, Eno Louden and Skeem find that probation officers systematically endorse forced treatment for probationers with mental illness despite evidence that it is rather ineffective at reducing recidivism and may in fact cause harm when forced (2013:32). In another review, Lamb and Weinberger note the lack of adequate discharge plans that are available to individuals with serious mental illness in the correctional setting (2013:290). Without adequate planning, psychiatric facilities and other community-based resources are often unable or unwilling to accept these individuals upon release, causing the necessary re-entry support mechanisms to chronically fail (Binswanger et al. 2011; Hammett, Roberts, and Kennedy 2001).

As these studies show, criminal justice and mental health systems have major discrepancies in their approach to addressing issues related to mental illness. For mental health boundary spanners, these discrepancies are skewed toward – if not dominated by – criminal justice processing. Together, these issues blend the action component of their

organizational role and the interpretive component of their professional prerogative. Following this approach, I ask whether or not mental health boundary spanners perceive any relevant tensions between their tasks (i.e. the professional duties associated with their organizational role) and their tools (i.e. the autonomy and decision-making power associated with their professional prerogative)? If so, how do such tensions manifest, primarily within the context of various justice-mental health interventions?

Reconciling Tasks and Tools

The creation and maintenance of boundary spanning relationships relies on the routinization – or the programmed nature – of the boundary role. In effect, the process of routinization serves a protective function for organizations by ensuring consistency with organizational procedures, norms, and goals (Aldrich and Herker 1977). According to Aldrich and Herker, "The existence of standard operating procedures partially protects the organization against attitudes and behaviors that are not consistent with organizational objectives" (1977:226). However, given that both sides of the boundary role must respect the incumbent's knowledge and expertise, the organizational dynamic of routinization presents a key challenge for boundary spanners. In particular, it requires them to balance their own credibility within the focal organization and among the external influences with whom they regularly interact (Abbott 1988:87; Aldrich and Herker 1977:226; Steadman 1992:84).

Lipsky captures a similar dynamic in his portrait of the street-level bureaucrat (2010). Specifically, Lipsky describes the process of 'decoupling' among street-level bureaucrats. Lipsky writes, "One important way in which street-level bureaucrats

experience their work is in their struggle to make it more consistent with their strong commitments to public service and the high expectations they have for their chosen careers" (2010:xiv). In response to various limitations and service constraints, street-level bureaucrats actively modify their conceptualization of their work and their relationship to their clients. As Lipsky explains (2010:xv):

> They believe themselves to be doing the best they can under adverse circumstances, and they develop techniques to salvage service and decision-making values within the limits imposed on them by the structure of the work. They develop conceptions of their work and of their clients that narrow the gap between their personal and work limitations and the service ideal.

Borrowing from institutional and organizational theory (Meyer and Rowan 1977), Lipsky suggests such decoupling or loose coupling techniques allow street-level bureaucrats to accept their work as being accomplished in the best possible way under prevailing circumstances (2010:82). Interestingly, Lipsky finds that such compromises are often incorrectly rationalized as individual dispositions toward the work rather than the result of prevailing structural constraints and actual organizational circumstances.

Other scholars, including Scheid (2000), conceptualize decoupling techniques within an 'institutional logics' framework[4]. According to Thornton and colleagues, institutional logics are defined as (Thornton, Ocasio, and Lounsbury 2012:2):

> The socially constructed, historical patterns of cultural symbols and material practices, including assumptions, values, and beliefs, by which individuals and organizations provide meaning to their daily activity, organize time and space, and reproduce their material lives and experiences.

[4] The title of this dissertation, "Safety as Care," is derived from the framework of institutional logics (Thornton and Ocasio 2008). For more on the meaning of the title, see additional analyses in Chapter 6.

The core meta-theory of institutional logic posits, "In order to understand individual and organizational behavior, it must be located in a social and institutional context, and this institutional context both regularizes behavior and provides opportunity for agency and change." (Thornton and Ocasio 2008:101). Thornton and Ocasio theorize virtually any societal context may be influenced by two or more contending logics (2008:104). Moreover, when the pressures of conflicting logics are great enough to create significant role strain, individuals and organizations will decouple or loosely couple who they are from how they act (Thornton et al. 2012:58).

As Scheid (2000) posits, "The institutional logic of commodification is in direct conflict with professionally-based logics of mental health care" (2000:703). Although mental health professionals' autonomy and decision-making powers are particularly vulnerable to the external pressures of commodification, Scheid finds multiple examples of responses to this threat that reflect mental health professionals' inclination to work within the frameworks imposed by commodification rather than challenge the system altogether (2000:713). In another study of how front-line professionals navigate discrepant institutional logics, Chiarello (2015) examines pharmacists' discretion and decision making as they combat prescription drug misuse. In this context, Chiarello suggests pharmacists primary organizing principles and practices are associated with logics in both criminal justice and medicine (2015:93). Drawing upon semi-structured interview data, Chiarello explores how these discrepant logics shape pharmacists' professional interactions and influence their decisions behind the pharmacy counter. Chiarello finds that

pharmacists manage competing institutional logics by interpreting and enacting a combination of medical and legal gatekeeping processes (2015:111).

As previously discussed, criminal justice and mental health systems have major discrepancies in their approach to addressing issues related to mental illness. This dynamic has the potential to constrain mental health boundary spanners' professional prerogative, leaving them with a considerable gap between the realities and constraints of their practice and their service ideals. In addition to identifying the nature of this gap, I am also interested in exploring whether and how mental health boundary spanners attempt to balance the tensions between their tasks and their tools. Specifically, how do they reconcile their work constraints and service ideals?

Collaborative and Practical Implications

The decoupling process noted above is a protective mechanism for mental health boundary spanners, particularly as they cope with the tensions between their tasks and their tools (Friedland and Alford 1991:254; Lipsky 2010:83; Scheid 2000; Thornton and Ocasio 2008:117). Through various decoupling techniques, they reconcile these tensions by accepting their work as being accomplished in the best possible way under prevailing circumstances. However, the extent to which they concede or maintain their ideals has 'collaborative implications' for the quality and appropriateness of the services they provide.

Mental health boundary spanners are particularly vulnerable to a specific type of external influence known as 'dual loyalty' (Bloche 1999; Scheid 2000:714). Dual loyalty is defined as, "The clinical role conflict between professional duties to a patient and

obligations, express or implied, real or perceived, to the interests of a third party such as an employer, and insurer, or the state" (Bloche 1999; Physicians for Human Rights 2002). According to leading medical ethicists, this dual loyalty phenomenon requires health professionals to balance the medical needs of their patients with the non-medical interests of a third party (Bloche 1999; Physicians for Human Rights 2002). Perhaps not surprisingly, dual loyalty concerns are particularly salient in immigration detention facilities, prisons, jails, and psychiatric institutions (Physicians for Human Rights 2002; Physicians for Human Rights 2011; Spiegel, Kass, and Rubenstein 2019). Health care professionals working in these particular settings have a limited capacity to uphold their professional standards. As an organizational matter, "Many health professionals working in this environment are subject to employment arrangements that formally subordinate them to officials responsible for institutional operation, thus compromising their ability to exercise independent judgment" (Physicians for Human Rights 2002). Throughout these settings, patient interests are rather secondary to the financial, political, or administrative agendas of the institution (Physicians for Human Rights 2002).

Mental health boundary spanners are quite susceptible to dual loyalty, particularly given the institutional and organizational demands on their work and their general loss of professional prerogative. Still, they must work to enhance their clinical autonomy and continue serving their patients' best interest (Physicians for Human Rights 2002). Here, I am interested in the collaborative implications of dual loyalty among mental health boundary spanners. Specifically, to what degree does dual loyalty influence the

development of their professional relationships with their justice counterparts and the individuals they serve?

In addition to generating dual loyalty concerns, many of the same work-related tensions also produce specific liability concerns and have the potential to manifest a perceived – if not real – lack of practical recourse. For instance, Scheid (2000) notes the 'managed care' framework associated with the logic of commodification has routinely failed to support best clinical practices by restricting needed hospitalizations and neglecting community support services. Scheid finds these restrictions have implications for mental health professionals' perceptions of liability. In particular, Scheid writes, "The perception is that if managed care entities are making the ultimate decisions about client care (rather than the provider) they should be accountable when their decisions results in personal loss or harm" (2000:714). Critically, however, Scheid argues that 'managed care' institutions and organizations do not bear these social costs in the end. Instead, they fall to mental health professionals, their clients, and the broader community (Scheid 2000:716).

Beyond specific concerns of liability, Scheid also addresses the perception among mental health professionals that 'managed care' represents a general lack of recourse for the clients they serve. Scheid notes, "Mental health providers believe that medication is important, but it is not necessarily the principal basis of treatment – instead, psychotherapy, rehabilitation, or other types of therapeutic options are also seen as critical components of treatment" (2000:703). However, given the emphasis on cost-containment and clearly identifiable outcomes under the prevailing 'managed care' framework, providers are pressured to emphasize psychiatric medication and limit their services to short-term

therapeutic interventions (Scheid 2000:710). According to Scheid, individual clients with chronic mental illness are left without recourse in these settings, particularly since there is little incentive for 'managed care' organizations to provide long-term service support (2000:711).

In the justice-mental health context, Draine and colleagues (2007) review the notion of 'limited recourse' by assessing three major service models and exploring their capacity to respond to the treatment needs of justice-involved individuals with serious mental illness. According to Draine and colleagues, the intervention service models frame treatment access simply as an issue of linkage to existing community resources without critically assessing service system capacity. Specifically, they write, "What is often not mentioned is that these intervention systems are designed to screen out the 'inappropriate' people without offering treatment options for the group that is screened out (2007:169). In effect, these screening procedures limit treatment options for the vast majority of justice-involved individuals with serious mental illness. In another review, Lamb and Weinberger (2013) consider the broad context in which community-based treatment interventions fall short. In particular, Lamb and Weinberger focus on, "A neglected group," of individuals who cycle in and out of acute psychiatric hospitalization, frequently come to the attention of law enforcement, and are at the greatest risk for criminalization (Lamb and Weinberger 2013:288). In terms of addressing the needs of this particular group, Lamb and Weinberger suggest there is no single recourse available to the criminal justice and mental health systems (2013).

For mental health boundary spanners, the consistent lack of practical recourse underscores the uniquely tense and frustrating professional experience of providing direct mental health services to justice-involved populations. Fisher and Drake (2007:547) offer a sharp commentary reflecting the insufficiency of various justice-mental health intervention programs:

> Such interventions, although critical, are grossly insufficient means for meeting the social support, employment, housing, education and other needs that, when left unaddressed, elevate individuals' risk of needing those jail-based services in the first place and over and over again.

Here, I am interested in the 'practical implications' of this dynamic. Specifically, to what extent do the mental health boundary spanners perceive a strict sense of liability in their work? Moreover, how do they conceptualize the limited recourse available within the context of the services they provide?

RESEARCH METHODOLOGY

The data for this project stem from a series of ethnographic observations with mental health professionals working in various justice-oriented contexts. In particular, this study focuses on mental health professionals who provide community-based crisis intervention services, jail-based mental health services, and community-based mental health services for adults on probation and parole. The three specific programs in this study are all located in Austin, Travis County (TX), and represent a range of justice-mental health interventions and service models in the area.

The Expanded Mobile Crisis Outreach Team (EMCOT) is operated through Integral Care, which is the local mental health authority (LMHA)[5] in Travis County. EMCOT's main goal is ensuring that individuals in the community who are experiencing a mental health crisis are in a position to receive appropriate treatment and support. EMCOT receives their referrals for crisis service exclusively through the local law enforcement and emergencies services dispatch. Most of the mental health professionals working at EMCOT are either Licensed Professional Counselors (LPCs), Licensed Clinical Social Workers (LCSWs), or Licensed Practitioners of the Healing Arts (LPHAs). In addition, the EMCOT mental health staff includes a licensed Nurse Practitioner (NP). The EMCOT counselors respond the crisis referrals in the community in real time. My ethnographic observations with the EMCOT counselors include 'ride-alongs' and other shadowing procedures, and I am particularly focused on their interactions and experience working with law enforcement and emergency first response personnel.

The Travis County Sheriff's Office (TCSO) employs two teams of mental health professionals. One team is based in the Central Booking facility in downtown Austin, and the other team is based in the larger Correctional Complex on the outskirts of town. Across both jail locations, TCSO mental health services include intake screening, routine assessment, and psychiatric support for individuals in custody at the jail. Most of the TCSO mental health staff are counselors (either LPCs, LCSWs, or LPHAs), but the teams also

[5] For review of mental health authorities and their emergence within the movement toward community-based psychiatric care, see: Mechanic, McAlpine, and Rochefort 2013; Morrissey et al. 1994; Wolff 1998:149.

include a licensed Psychiatrist and NP. The jail counselors conduct routine psychiatric assessments in order to provide 'housing' recommendations to corrections staff, treatment recommendations to other mental health staff, and mental health status updates to court liaisons. My ethnographic observations with the jail counselors include shadowing procedures inside both jail locations, and I am particularly focused on their interactions and experience working with correctional staff.

Like, EMCOT, the ANEW program is operated through Integral Care. ANEW's main goal is ensuring that individuals on probation and parole receive targeted mental health treatment services in the community. ANEW receives direct referrals for case management from Travis County Adult Probation and the Texas Department of Criminal Justice. ANEW's mental health staff includes a licensed Psychiatrist, and many of the case managers are either LPCs, LCSWs, or LPHAs. However, some of the case managers working at ANEW are not professionally licensed counselors. The ANEW case managers conduct routine mental health assessments, and support their clients by introducing them to specific behavioral and emotional learning skills and connecting them to other socioeconomic resources in the community. ANEW's main clinic is located on the ground floor of the Travis County Adult Probation office building. ANEW also has a small office inside the Austin Transitional Center (ATC), which is a residential transitional center for individuals on parole. My ethnographic observations with the ANEW case managers include shadowing procedures inside both facilities. I am particularly focused on their interactions and experience working with probation and parole staff.

The qualitative analyses in this dissertation explore the ethnographic data[6] within the context of each site. I present core ethnographic scenes, shorter vignettes, and key quotes to illustrate the professional experience of providing mental health services in these justice-oriented contexts. In addition to presenting the thematic findings, I also present an overarching research argument that considers the findings across all contexts. Given the diversity of mental health services offered in coordination with local justice agencies, I operationalize the term 'mental health professional' to include psychiatric clinicians, mental health counselors, social workers, and other similar occupations. However, within each context of each research site, I consider how the provision of direct services is influenced by specific professional roles.

RESEARCH FINDINGS

Mental health boundary spanners who provide direct services in various justice-oriented contexts reconcile the tensions between their occupational constraints and service ideals by conceptualizing their work as 'planting a seed' among the individuals they serve, particularly with the hope that a pattern of sustained engagement with other direct services will emerge. However, in my analysis of the ethnographic data across each of the research sites in this study, I find that 'planting a seed' is the practical ceiling of these cross-system interventions. Instead of providing transformational mental health care that reduces justice involvement and recidivism, the mental health boundary spanners perceive the

[6] This research is sanctioned by the Institutional Review Board (IRB) at the University of Texas at Austin, as well as the IRB at Integral Care and the organizational leadership at TCSO.

organizational and institutional function of their services in 'people processing' terms, shifting individuals when possible from one system to the other (Fisher and Drake 2007:547; Hasenfeld 1972).

In Chapter 3, I describe how jail counselors conduct routine mental health assessments and make subsequent housing recommendations to the correctional staff. I find there are specific disconnects between inmates' psychiatric needs and the limited services that the jail counselors are able to provide. The jail counselors experience this disconnect as their patients, "Fall through the cracks," but they reconcile these concerns by limiting their service expectations. In particular, they conceptualize, "Getting a win," in terms directly associated with their service constraints. Despite the development of relatively sustainable work-related perspectives, the jail counselors continue to frame their professional experience as extremely isolating. Moreover, they express specific concerns of liability stemming from their housing decisions, and a general sense of unease with respect to the lack of recourse available to the inmates at the jail. In sum, they feel their work in the jail is situated in, "The worst of all worlds."

In Chapter 4, I describe how EMCOT counselors engage with exclusive referrals for crisis intervention services. Despite their efforts to connect individuals experiencing psychiatric crisis to appropriate sources of care as soon as possible, I find the EMCOT counselors are often constrained by the voluntary nature of the services they provide. They perceive this limitation on their service objective as particularly frustrating, and recognize that it sets them up for, "Other problems down the road." In response to the tensions associated with their clients' voluntary service engagement, the EMCOT counselors

reconceptualize their service ideals by viewing crisis intervention as a potential moment in which new patterns of client trust can emerge. However, I find that the EMCOT counselors are also required to manage the expectations of their community partners with rather limited resources. These tensions combine to produce a frequent sense of helplessness among the EMCOT counselors, who perceive their work as being situated, "In between two worlds."

In Chapter 5, I describe how ANEW case managers provide mental health services to individuals on probation and parole. I find the ANEW case managers' service objectives often blend with the technical terms and requirements of their clients' justice supervision. In an effort to balance this dynamic for their clients, the ANEW case managers emphasize the, "Shades of grey," that various technicalities overlook. For instance, the ANEW case managers work to validate their clients' trauma and extreme vulnerability. Despite these adjustments to their service perspective, other organizational pressures continue to limit their view of work-related success. The ANEW case managers frame these sustained pressures as, "The need to feed the beast."

RESEARCH CONTRIBUTIONS

In this study, I find that mental health boundary spanners' practical experience is particularly frustrating, especially given their loss of professional prerogative and the limited recourse available to the individuals they serve. As such, I suggest that 'planting a seed' is the practical ceiling of these cross-system interventions, while 'people processing' is their norm. According to Hasenfeld, "People processing organizations are defined as attempting to achieve changes in their clients not by altering basic personal attributes, but

by conferring on them a public status and relocating them in a new set of social circumstances" (1972:256). This study supports the view that justice-mental health intervention programs serve a 'people processing' function. As Fisher and Drake (2007:547) note:

> Historically, societal pressure to institutionalize persons with mental illness has been a constant. Only the names of the institutions change: almshouses, hospitals, "ships of fools," nursing homes, homeless shelters, jails. The modern temper, however, uniquely promotes medicalizing and criminalizing social problems… placing greater and greater pressures on overburdened mental health and criminal justice systems to control the tragic circumstances that society has created.

Although this research is not intended to be a program evaluation or quality improvement project, the findings nonetheless contribute to contemporary discussions that contextualize the function and purpose of reform (Bell 2017; Brayne and Christin 2000; Engel et al. 2020; Wood, Watson, Fulambarker 2017).

Recent efforts to reform the criminal justice system have resulted in new practices in policing, prosecution, corrections, and other community supervision programs. For instance, police officers in Texas now receive additional training for crisis intervention (Sandra Bland Act 2017), and local prosecutors are being elected to public office on campaign platforms of wholesale justice reform (Hall 2020). Despite these changes and others, many scholars remain skeptical of the implications and overall consequences of procedural justice reform (Bell 2017). For instance, some scholars suggest such reforms actually serve to reinforce the legitimacy of the police and the power of the state (Engel et al. 2020; Gorz 1968). Similarly, other scholars find they entrench the production of inequality (Brayne and Christin 2020). This research sheds light on the recent proliferation

of justice-mental health reforms and intervention policies. Increased connections to mental health care are noble – if not necessary – criminal justice reforms (Fisher et al. 2006; Fisher and Drake 2007). However, as this research shows, such efforts may do more to change the provision of mental health care than the actual systems of justice processing.

Chapter 2: Research Methodology

In this chapter, I review the study's project design by introducing the 'local landscape' of justice-mental health initiatives in Austin, Travis County (TX). Specifically, I describe the key justice-mental health interventions and service models that have been developed in recent years by the criminal justice and mental health agencies at the local level. Then, with the local landscape in mind, I review the field entry strategy and data collection protocols, including specific details associated with the manner of ethnographic observations in each site. I end this chapter with a discussion of my approach to the analysis of the ethnographic data. In each section, I also review the strengths and weakness of the methodological approach.

PROJECT DESIGN

Local Systems in Context

Local leaders in jurisdictions across the United States refer to the Sequential Intercept Model (SIM) as a blueprint for spawning their own concrete justice-mental health initiatives (Munetz and Griffin 2006). In these terms, Austin, Travis County resembles many of larger local jurisdictions across the United States in terms of developing and implementing contemporary service models and interventions. For instance, according to a report published by the Austin Travis County Behavioral Health Advisory Committee (Oshatz and Hohengarten 2015), the strategic intervention policies that have been developed at the local level since 2008 include: (1) the formation of a Mobile Crisis Outreach Team as a pre-arrest diversion strategy, (2) a mental health docket and a mental health bond program as alternatives to incarceration, and (3) re-entry programming for

individuals with serious mental illness on probation or parole. Table 2.1 illustrates these mental health service models in the context of their justice system processing intercept points. To be sure, these particular interventions represent a fraction of all justice-mental health initiatives in Austin, Travis County (Oshatz and Hohengarten 2015).

In this study, I focus on three separate programs, including one at each level of pre-arrest diversion, jail processing and corrections, and community re-entry and supervision. As I describe in the paragraphs below, all three programs are primarily situated in the context of justice system processing, but they each have their own specific mental health service objectives. Importantly, the three programs in this study represent a range of justice-mental health interventions in the local area (Oshatz and Hohengarten 2015), which is an overall strength of the project design. Given this approach, I am able to explore variation in the professional experience of mental health boundary spanners across separate justice-oriented contexts. Moreover, since two of the programs are operated through Integral Care (IC) and the other program is operated through the Travis County Sheriff's Office (TCSO), I am able to explore the organizational influences in both the criminal justice and mental health systems. One potential weakness of the study design is that the findings are nonrepresentative of other local jurisdictions across the state and country. However, as I previously mentioned, larger jurisdictions in the United States are beginning to implement many of these same justice-mental health interventions and service models. For instance, Atlanta, Boston, Houston, Indianapolis, Los Angeles, and Seattle all have mobile crisis outreach teams that work in direct coordination with local law enforcement personnel (Watson, Compton, and Pope 2019).

Intercept	Program	Description
Pre-arrest	Crisis Intervention Teams (CIT)	The Austin Police Department and the Travis County Sheriff's Office have teams of law enforcement personnel who work to divert PSMI in the community away from the criminal justice system.
	Expanded Mobile Crisis Outreach Team	Mental health counselors with Integral Care receive referrals exclusively from local law enforcement in an effort to provide direct services to individuals experiencing mental health crisis in the community.
Jails	Jail Counseling and Psychiatric Services	Mental health counselors with the Travis County Sheriff's Office provide screening, assessment, and other support services to inmates at the jail.
Courts	Mental Health Public Defender (MHPD)	Attorneys with the Travis County MHPD Office provide specialized legal representation and other social services to support defendants with SMI.
	Misdemeanor and Felony Mental Health Dockets	Collaborative problem-solving dockets for defendants with SMI who have been charged with low-level misdemeanors and low-level felonies, respectively.
Re-entry	ANEW	Mental health counselors with Integral Care work with Travis County Adult Probation and the Texas Department of Criminal Justice in an effort to provide case management services for PSMI on probation or parole.

Table 2.1: Sample of SIM-based Programs in Austin, Travis County.

The first program in the study is the Expanded Mobile Crisis Outreach Team (EMCOT) at Integral Care, which is the local mental health authority (LMHA) in Austin, Travis County. EMCOT's main goal is ensuring that individuals in the community who are experiencing a mental health crisis are in a position to receive appropriate treatment and support. EMCOT receives their referrals for crisis service exclusively through the local law enforcement and emergencies services dispatch. Most of the mental health professionals working at EMCOT are either Licensed Professional Counselors (LPCs), Licensed Clinical Social Workers (LCSWs), or Licensed Practitioners of the Healing Arts (LPHAs). In addition, the EMCOT mental health staff includes a licensed Nurse Practitioner (NP). The mental health professionals at EMCOT respond to referrals for crisis intervention in the community in real time.

The second program in the study is operated by the Travis County Sheriff's Office (TCSO), which employs two teams of mental health professionals. One team is based in the Central Booking facility in downtown Austin, and the other team is based in the larger Correctional Complex on the outskirts of town. Across both jail locations, TCSO mental health services include intake screening, routine assessment, and psychiatric support for individuals in custody at the jail. Most of the TCSO mental health staff are counselors (either LPCs, LCSWs, or LPHAs), but the teams also include a licensed Psychiatrist and NP. The mental health professionals at the jail conduct routine psychiatric assessments in order to provide 'housing' recommendations to corrections staff, treatment recommendations to other mental health staff, and mental health status updates to court liaisons.

ANEW is the third program in the study, and – like EMCOT – it is operated through Integral Care. ANEW's main goal is ensuring that individuals on probation and parole receive targeted mental health treatment services in the community. ANEW receives direct referrals for case management from Travis County Adult Probation and the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), which is a division of the Texas Department of Criminal Justice (TDCJ). ANEW's mental health staff includes a licensed Psychiatrist, and many of the case managers are either LPCs, LCSWs, or LPHAs. However, some of the case managers working at ANEW are not professionally licensed counselors. The mental health professionals at ANEW conduct routine mental health assessments, and support their clients by introducing them to specific behavioral and emotional learning skills and connecting them to other socioeconomic resources in the community. The ANEW program's main clinic is located on the ground floor of the Travis County Adult Probation office building. ANEW also has a small office inside the Austin Transitional Center (ATC), which is a residential transitional center for individuals on parole.

Given the diversity of mental health services offered in coordination with local justice agencies, I operationalize the term 'mental health professional' to include psychiatric clinicians, mental health counselors, social workers, and other similar occupations. This approach allows me to explore the experience of providing direct mental health services from the perspective of multiple professional statuses. That being said, the vast majority of the mental health professionals represented throughout the course of my ethnography are mental health counselors and social workers (LPCs, LCSWs, and LPHAs).

In particular, they comprise many of the boundary roles within the intervention programs and service models, and they further share a similar professional status compared to psychiatrists and nurse practitioners.

DATA COLLECTION

Access to the Research Sites

In order to gain the necessary research clearance and jail access permissions from TCSO, I spent a considerable about of time meeting with their organizational leadership[7]. First, I contacted the Mental Health Services Director at TCSO and made a formal introduction via email. The director subsequently invited me to meet with him in his office at the Travis County Correctional Complex (TCCC), which is one of the jails two main locations. After discussing the proposed study, the Mental Health Services Director at TCSO invited me to give a formal presentation to the counselors at TCCC and Central Booking. I used the presentation as an opportunity to explain my goals for the project. In particular, I explained that I was primarily interested in learning more about their professional experience and perspective. Given that my field entry strategy was top-down, from the organizational leadership to the front-line professionals, I wanted to make sure that I was continually reassessing the research participants' informed consent. That is, I did

[7] This research is sanctioned by the Institutional Review Board (IRB) at the University of Texas at Austin. Specifically, the study received an exempt determination in January 2019 (Protocol Number 2018-11-0055). In addition to receiving approval from the IRB at the University of Texas at Austin, I had to apply for and receive jail access permissions and research clearance from the Travis County Sheriff's Office.

not want the mental health staff at the jails to feel that they were being required to participate in the study. To be sure, their participation was not required at any point. After my initial meetings and presentations at TCCC and Central Booking, it was my sense that the mental health staff was rather eager to participate and tell their stories. Indeed, I did not receive any objections to my research presence in the jail from the mental health staff or their supervisors.

In my effort to connect with the mental health professionals at EMCOT and ANEW, I was required to navigate a similar process with Integral Care's organizational leadership[8]. First, I first contacted the Director of Crisis Services at Integral Care via email. The director subsequently invited me to meet with her in her office in the organization's administrative headquarters. After discussing the proposed study, the Director of Crisis Services encouraged me to connect with the program managers at EMCOT and ANEW in order to learn more about what an actual observational study might entail. So, I reached out to the program managers, and met with each of them one-on-one to discuss the parameters of their respective operations. Then, I drafted research access agreements with EMCOT and ANEW, and made a formal presentation to Integral Care's internal IRB. After receiving their approval, I circled back to the EMCOT and ANEW programs so that I could properly engage the front-line mental health professionals in the process of informed consent. Again, given my top-down approach to entering the field, I wanted to be clear

[8] In addition to being approved by the IRB at the University of Texas at Austin and the organizational leadership at TCSO, this research is further sanctioned by the IRB at Integral Care.

with the counselors at EMCOT and ANEW that they were not required to participate in the study. I made another round of formal presentations to the mental health professionals on each team, and I distributed an information sheet with specific details about the proposed study. To my knowledge, none of the mental health professionals at EMCOT or ANEW objected to my presence in their respective fields.

Access to Specific Interactions

Officially, I began my fieldwork with EMCOT in March 2019. My ethnographic observations with the EMCOT counselors included 'ride-alongs' and other shadowing procedures, and I was particularly focused on their interactions and experiences with law enforcement personnel and other emergency first responders. On a weekly basis, I would coordinate with the EMCOT supervisors and schedule specific times and dates to shadow the counselors in the field. I was able to capture their work experience over a range of different periods, including weekdays, weekends, early morning, midday, evening shifts. Based on certain scheduling parameters, the EMCOT supervisors would tell me which counselors would be available on any given day. While shadowing individual EMCOT counselors, I would re-invest in my effort to maintain informed consent – even if I had previously shadowed with that particular counselor. One of the primary issues that I wanted to balance was my desire for research access and the counselors' own relationship to their clients in the field. So, for instance, when I would shadow the EMCOT counselors during a particular emergent response, I would have a conversation with them about arriving on the scene of the referral. For the most part, I would only get out of the vehicle during the counselor's initial interaction with the law enforcement personnel. Then, after the

counselor and the first responder exchanged background information about the case, I would typically step back into the vehicle and wait for the counselor to conduct the assessment with the client. The clients were usually out of sight, either inside their home or some business, but the client would occasionally be outside in plain view. In these instances, I always followed the counselor's lead and only engaged with other first responders on the scene.

The EMCOT counselor's assessments would last anywhere from twenty minutes to multiple hours, largely depending on the client's needs. The longest I waited was two hours, although counselors would often describe even longer, "Marathon calls." During some shifts, the EMCOT counselors would get zero referrals. Other times, they would receive back-to-back referrals for hours on end. In the moments between referrals and assessments, the counselors and I would freely engage in discussions about their work. Although I never had a strict agenda or questionnaire, I would often direct the conversations to cover the general themes related the research. For instance, after a referral and assessment, I would ask the counselors to describe their interaction with the other first responders and the connections they were able to make with the individual receiving services. I used the Google Drive application on my cellphone to take the vast majority of my fieldnotes throughout my time shadowing the EMCOT counselors in the field. The EMCOT counselors use multiple electronic devices to coordinate and exchange information in the emergent setting, so I felt very comfortable using my phone to take notes. Still, I always carried a moleskine notebook with me as a primary backup. I would always secure my digital and hand-written notes after each observation in the field.

After nearly three full months in the field with EMCOT, I began conducting observations with the counselors at the jails in June 2019. My ethnographic observations with the jail counselors included shadowing procedures inside both jail locations. I was particularly focused on observing the counselors' interactions and experiences with TCSO correctional staff. On a weekly basis, I would coordinate with the counseling supervisors at Central Booking and TCCC in an effort to schedule specific times and dates for observation.

At Central Booking, I was able to capture a range of different shifts, including weekdays, weekends, early morning, midday, evening, and late-night periods. In some timeframes, I would be at Central Booking from 9:00pm on Friday night until 2:00am on Saturday morning, and then return to the jail on Sunday morning at 6:00am for another round of observations. While shadowing the counselors at Central Booking, I would follow them around from their offices to the various 'Posts' throughout the jail where they would conduct their routine assessments. While inside the various Posts, I would station myself near the desk of the commanding officer on duty. These desks were large switchboards with clear views into the Posts, which allowed me to see and hear much of the counselors' action. Since I did not require access to the counselors' interactions and assessments with individuals in the custody of the jail, I felt it was unnecessary to closely follow the counselors throughout the various Posts. If I ever had any questions about a particular interaction or experience, then I would follow up with the counselors as soon as we got back to their office.

At TCCC, the 8:00am to 6:00pm counseling shifts throughout the week provided a much more consistent observation schedule, especially compared to the variability in counseling shifts at Central Booking. For instance, my typical observations with the counselors at TCCC would begin at 8:00am and end in the early afternoon. The bulk of the counselors' daily interaction occur during the late morning hours when they are conducting their routine assessments with individuals in custody at the jail. While shadowing the counselors throughout the various 'Units' at TCCC, I would typically stand near desk of the commanding officer on duty. From this position, I would have a clear view of the Units and I could track the counselors' interactions. Similar to my observational approach inside the Posts at Central Booking, I did not feel that it was necessary infringe upon the counselors' individual assessments or otherwise follow them too closely around the Units as they visited individual cells.

TCSO restricts all access to cellphones and electronics inside the jail facilities, so my fieldnotes in these settings were handwritten in volumes of moleskine notebooks. On the days that I was scheduled to observe at the jails, I would simply bring a moleskine notebook and a pen. Upon my arrival at the jails, I would pass through the security checkpoints and metal detectors, exchange my driver's license for a jail access visitor's badge, and navigate my way through the jail to the counselor's offices. Although I was given non-escort clearance throughout most of the jail settings, my primary purpose for being at the jail was to follow the counselors and shadow them throughout their daily shifts. On a few rare occasions, the TCSO deputies would ask me about my notes or my notebook. In these instances, I would be clear and upfront with the deputies about my purpose and

presence in the facility as a researcher. For the most part, however, the counselors would first introduce me to the deputies as a welcomed guest.

After nearly three full months of observations in the jails, followed by a month-long break from fieldwork in September, I began conducting observations with the ANEW case managers in October 2019. My ethnographic observations with the ANEW case managers included shadowing procedures inside their two main office locations. I was particularly focused on their interactions and experiences with probation and parole staff. On a weekly basis, I would coordinate with ANEW's program manager in an effort to schedule specific times and dates to shadow the case managers in their office setting. In my time conducting fieldwork with ANEW, I was able to observe the case managers working in both office settings (i.e., the ANEW offices in the Travis County Adult Probation building, and the ANEW offices at the Austin Transitional Center). There were very few scheduling parameters with the ANEW case managers. The clinics were open Monday through Friday from 8:00am to 6:00pm. The primary issue with regard to access, however, was the fact that the case managers had one-on-one meetings with their clients scheduled throughout the day. As such, I would bounce from one office to another, meeting with individual case managers as they became available throughout the day. I never observed the case managers meeting one-on-one with their clients. I considered those interactions to be private and confidential, and also entirely unnecessary for my review. Instead, I would meet with and observe the case managers in their offices between meetings, or in particular instances when a client would not show up for a scheduled appointment.

The ANEW clinics at both locations were guarded by security personnel, and all visitors were required to pass through metal detectors. Similar to the jail settings, most visitors were restricted from using their cellphones and electronic devices. However, with clearance from Integral Care and ANEW's program manager, I was allowed to use my cellphone to take fieldnotes in the office settings. I used the Google Drive application on my cellphone to take contemporaneous notes of my observations and discussions with the ANEW case managers. Still, I always carried a moleskine notebook with me as a primary backup. Moreover, I would always secure my digital and hand-written notes after each observation in the field.

I officially completed my fieldwork in January 2020, after nine months of observations with the mental health professionals at EMCOT, TCSO, and ANEW. Across the three programs, I shadowed a total of forty-five individual mental health professionals – many of whom I followed on several different occasions. Immediately after each observation, I would spend time reviewing my fieldnotes and supplementing the data with mental notes while they remained fresh in my memory. Then, beginning in February 2020, I compiled my all of my fieldnotes and created a chronological transcription of the ethnographic and observational data. The findings and analyses of this dissertation are based on this complete record of the data.

Although the fieldnotes are rather extensive, there are few instances of audio and video files within the record of the data. In part, this limitation was forced as a matter of access. Specifically, TCSO and Integral Care restricted my use of audio and video recordings while conducting fieldwork with their staff. The privacy and protection of the

mental health professionals was a key piece of this restriction, as was the confidentiality of their interactions with the individuals they serve. Despite these restrictions, my fieldnotes include many direct quotes and detailed descriptions of the physical environment in which the participants operate.

In addition to the series of observations within the three primary research sites, I also conducted a number of observations and interviews in various peripheral settings. On record, I interviewed various judges, prosecutors, and defense attorneys about their work in the context of the criminal justice and mental health systems. These interview transcripts compliment the overall data record of the project, but they are not included here for the purposes of this dissertation, which focuses primarily on the delivery of specific mental health services from the perspective of mental health professionals.

DATA ANALYSIS

Through my observational approach, I channel the 'Thick Description' posited by Geertz (1973:30) and other observational theorists. Specifically, Geertz writes, "To look at the symbolic dimensions of social action is not to turn away from the existential dilemmas of life; it is to plunge into the midst of them, and to make available to us the answers that others have given and include them in the consultable record of what man has said." Geertz suggests the intellectual effort that goes into the analysis of the observations is what defines the enterprise of ethnography. As he explains, "Doing ethnography is establishing rapport, selecting informants, transcribing texts, mapping fields, and so on. But it is not these things that define the enterprise. What defines it is the intellectual effort of the thick description" (Geertz 1973:6). By observing the mental health professionals in the course of their

everyday work, I am able to match what they say to what they do, and further contextualize their perspective in relation to the external influences and environment factors that surrounds them. The extensive fieldnotes based on these observations provide detailed accounts of the social relationships and personal perspectives of the study's participants.

There are certain limitations, however, to my observational approach. In particular, by only focusing on the accounts and perspective of mental health professionals, I limit my ability to capture the accounts and perspective of their professional counterparts in the criminal justice system, as well as the individual service recipients. In other words, I am unable to triangulate my analysis of these data through the accounts of other entities or stakeholders. I am, however, able to verify the extent wo which certain perspectives are shared among mental health professionals.

Given the research questions and conceptual frameworks outline in Chapter 1, I conduct my analysis of the data by identifying specific themes that emerge within each setting. How do the jail counselors describe their organizational role? What are the professional prerogatives of the EMCOT counselors? How do the ANEW counselors reconcile the tensions between their work-related constraints and their service ideals? I select core ethnographic scenes, shorter vignettes, and key quotes to illustrate the thematic findings. Then, with the findings mapped out, I consider the overall implications for justice-mental health interventions and service programs. That is, I situate mental health professionals' narratives within the contemporary context of social control, and further provide an overarching research argument that applies not just to the professionals in these research settings, but to the whole of the cross-system intervention service approach.

Chapter 3: Mental Health Services in the Jail Setting

In this chapter, I describe how jail counselors conduct routine mental health assessments and make subsequent housing recommendations to correctional staff. I find there are specific disconnects between inmates' psychiatric needs and the limited services that the jail counselors are able to provide. The jail counselors experience this disconnect as their patients, "Fall through the cracks," but they reconcile these concerns by limiting their service expectations. In particular, they conceptualize, "Getting a win," in terms directly associated with their service constraints. Despite the development of relatively sustainable work-related perspectives, the jail counselors continue to frame their professional experience as extremely isolating. Moreover, they express specific concerns of liability stemming from their housing decisions, and a general sense of unease with respect to the lack of recourse available to the inmates at the jail. In sum, they feel their work in the jail is situated in, "The worst of all worlds."

HOUSING RECOMMENDATIONS

The Travis County Sheriff's Office (TCSO) employs two teams of mental health professionals. One team is based in the Central Booking facility in downtown Austin, and the other team is based in the larger Correctional Complex on the outskirts of town. Across both jail locations, TCSO mental health services include intake screening, routine assessment, and psychiatric support for individuals in custody at the jail (inmates). Most of the TCSO mental health staff are counselors (either LPCs, LCSWs, or LPHAs), but the teams also include a licensed Psychiatrist and NP. Unless otherwise stated, the ethnographic data in this chapter pertain to my observations with the jail counselors. As I

find here, much of their work focuses on the 'housing' recommendations they provide to corrections staff.

Jail-based Services (Central Booking)

Central Booking at the Travis County jail is located in downtown Austin, TX. There is a heavily secured transportation bay located on the western side of the seven-story building. The transportation bay leads directly into the basement floor of Central Booking. The basement floor includes a series of intake and processing desks, an open holding area, six isolation cells, a medical intake and phlebotomy office, a mental health counselors' office, and a twenty-four-hour magistrate court.

During the primary custody exchange with the arresting officer at the intake desk, a TCSO deputy is responsible for completing an initial assessment of all inmates who are booked into the jail. This initial assessment is based on the TCSO Intake Assessment Form[9], which has three unique sections with a total of thirty-nine questions. The first twenty-one questions are specific to an inmate's immediate medical needs. For instance, "Are you currently taking any prescription medications?" If the inmate's response to any of the questions in the first section is "Yes," then the inmate is referred to the medical staff in Central Booking for a priority medical assessment. In the second section of the TCSO Intake Assessment Form, there are ten questions all related to the inmate's *immediate* psychiatric needs. For instance, one question asks, "Are you having thoughts of killing or injuring yourself?" If the inmate's response to any of the questions in the second section

[9] For review of the TCSO Intake Assessment Form, see Figure C.1.

is, "Yes," then the inmate is referred to the mental health counselors in Central Booking for an immediate psychiatric assessment. In the third section of the TCSO Intake Assessment Form, there are eight questions all related to the inmate's *routine* mental health needs. For instance, one question asks, "Have you ever received services for emotional or mental health problems?" If the inmate's response to any of the questions in the third section is, "Yes," then the inmate is referred to the mental health counselors in Central Booking for a routine psychiatric assessment, which must be completed within thirty-six hours of intake at the jail[10].

During the immediate and routine mental health assessments – which are indicated as necessary on the TCSO Intake Assessment Form by the deputy at the intake desk – the jail counselors make their initial housing determination based on the inmate's current psychiatric presentation. In other words, can the inmate be placed in a general population (GP) unit, or does the inmate need to be placed under acute psychiatric observation in a more secure unit? Table 3.1 below references the various housing designations associated with each unit, or "Post," in Central Booking. Specifically, Post 1 and Post 2 are both general population (GP) units for adult men, Post 3 is a general housing unit for adult women, and Post 4 is an acute psychiatric observation unit for adult men.

[10] Texas lawmakers passed S.B. 1849 during the 84th state legislative session (Sandra Bland Act 2017). S.B. 1849, otherwise known as the "Sandra Bland Act," required the Texas Commission on Jail Standards (TCJS) to update minimum jail safety standards and diversion protocols. Among other things, these changes shortened the amount of time that jails have to complete their mental health assessments upon intake, and further modified the requirements for jail diversion and community collaboration.

Unit	Population	Housing Description
Post 1	Adult Men	General Population
Post 2	Adult Men	General Population
Post 3	Adult Women	General Population, and Acute Psychiatric Observation
Post 4	Adult Men	Acute Psychiatric Observation

Table 3.1: Housing Scenarios in the Posts at Central Booking.

In addition to the immediate and routine psychiatric assessments that occur during intake, the jail counselors are also required to conduct a separate, follow-up assessment for *all* inmates who are booked into the jail. The follow-up assessments are called, "Counselor's Initial Follow-up Review," or CIFR. The jail counselors base their CIFRs on the TCSO Mental Health Screening Form[11], which primarily screens for information related mental health and substance use needs. The TCSO Classification Department (Class) requires the CIFRs to be completed prior to transferring inmates from Central Booking to the Travis County Correctional Complex (TCCC). As such, the inmates who did not receive a mental health flag during their initial intake assessment will nonetheless need to be assessed as 'defaults' by the jail counselors before they can be transferred to TCCC. In practice, the CIFRs mostly serve an extra safety precaution to ensure that an inmate's psychiatric presentation has not deteriorated since their intake assessment. Jane, who is a jail counselor at Central Booking, further explains, "Class is the bridge between

[11] For review of the TCSO Mental Health Screening Form, see Figure D.1.

Central Booking and the Correctional Complex. We have to have CIFRs closed by a certain time each day, or else Class gets irritated. It's a well-oiled machine."

There are two counseling shifts at Central Booking. The first counseling shift begins every morning at 6:00am and ends every afternoon at 4:00pm. The second shift begins at 4:00pm and ends at 2:00am. There are typically at least three counselors present for each shift; one counselor fills the intake assignment, and other two counselors fill the CIFR assignment. The counselor with the intake assignment is responsible for conducting the immediate and routine assessments for the inmates being processed at the intake desk down in the basement of Central Booking. Meanwhile, the counselors filling the CIFR assignment are responsible for conducting the follow-up assessments for all of the inmates who are currently housed in the Posts throughout the jail.

Regardless of their assignment, the jail counselors must complete their notes from every assessment before their shift ends. According to Jane, "The notes for the default inmates are quick and easy." She explains, however, that the inmates who received an immediate or routine psychiatric assessment will need more detailed notes. The jail counselors use the desktop computers in their shared offices at Central Booking to update the inmates' various records. Specifically, the jail counselors need to manage the inmates' electronic health records (EHR), and further update TCSO's correctional management operating system, which is called, "Tiburon." Since many of the notes in the EHR system contain confidential health-related information, login access is limited to the jail counselors and other mental health staff. Separately, the jail counselors use Tiburon to relay inmates' basic psychiatric status to the deputies and other correctional staff. For example, the "PSY"

code in Tiburon is the general indication that an inmate has been placed in the jail's psychiatric protocol, but it doesn't disclose the jail counselors' specific notes or confidential records.

In addition to these details, the counselors need to submit a Continuity of Care Query (CCQ) for each psychiatric inmate who is booked into the jail. The CCQs serve as an open line of communication between the jail and the Texas Department of State Health Services' mental health database (Hogg Foundation for Mental Health 2018:301; Texas Department of State Health Services 2018:1). Specifically, the CCQs are used to alert the jail counselors of whether or not an inmate has been hospitalized in a state psychiatric facility or if the inmate has received psychiatric care through a local mental health authority (LMHA) within the past three years (Hogg Foundation for Mental Health 2018; Texas Department of State Health Services 2018). The information contained within the CCQs is very high level: patient's name, date of birth, social security, and the name of the LMHA or state psychiatric at which the patient received care. However, the CCQs will not include any information related to whether or not the services are current or closed, or what types of services may have been provided to the patient. Despite the limited amount of information that is contained in the CCQs, Jane says they can provide important context for the jail counselors. According to the Texas Department of State Health Services (2018), between September 1, 2017 and June 22, 2018, a total of 872,350 CCQ were initiated across 235 county jails in Texas, and a total of 248,923 – or thirty-five percent – were either an exact or probable match. If an exact or probably match is detected through the CCQ, then the appropriate LMHA is notified in an effort to exchange any pertinent information.

Jail-based Services (Correctional Complex)

TCCC is located in the far southeast corner of the county, near the Austin-Bergstrom International Airport. TCCC is a large campus-style correctional facility with multiple buildings on approximately one hundred thirty acres of land (Travis County 2020). The vast majority of the inmates at TCCC are housed in the GP buildings. Alternatively, many of the inmates with acute psychiatric needs are housed in the Health Services Building, which has multiple psychiatric units reserved for specific populations. Table 3.2 references the various housing designations associated with the psychiatric units in the Health Services Building:

Unit	**Population**	**Housing Description**
HS-C, Charlie Unit	Adult Women	FSP, Y-OBS, Open Psych
HS-D, David Unit	Adult Men	Y-OBS
HS-E, Edwards Unit	Adult Men	Open Psych
Visual Check Hallway	Adult Men	FSP

Table 3.2: Housing Scenarios in the Health Services Building at TCCC.

The Charlie Unit of the Health Services Building (HS-C) is the only psychiatric unit reserved for women, and there are a total of fifty-two beds in the unit. Whereas the women's psychiatric unit includes multiple housing designations (FSP, Y-OBS, and Open Psych), each of the men's units have their own unique designation. For instance, HS-E is a fifty-two-bed unit for men in "Open Psych," which is a housing designation for inmates

who are not actively demonstrating behaviors that are dangerous to themselves or to others but nonetheless require close monitoring due to their psychiatric status.

The inmates who are housed in "Intensive Psychiatric Observation" (Y-OBS) have severe restrictions placed on the items they are allowed to keep in their cells, and a deputy is required to conduct a visual check at least every thirty minutes. The Y-OBS cells have large windows – approximately two feet wide and three feet tall – built into the cell door. Moreover, each of the Y-OBS cells have an even larger window built into the cell wall beside the cell door. These large windows provide a clear view into the cell for corrections staff and counselors.

"Full Safety Precaution" (FSP) is the most restrictive housing designation. While in FSP, inmates are stripped completely bare and a deputy is required to conduct a visual check of the cell at least every fifteen minutes. The walls inside the FSPs cell are covered with a firm padding material. The cell doors, which are also padded on the inside, only have a small window about five feet above the floor. The cells are barren, with the exception of a sewage grate in the middle of the floor.

Jail standards direct the counselors to assess housing appropriateness based on the least restrictive option for safety. Thus, in the absence of acute mental health needs, or when an inmate's psychiatric symptoms have a minimal impact on their daily functioning, GP is the appropriate housing option. However, inmates can be 'stepped up' to the psychiatric units if the counselors are concerned for their health and safety. For instance, counselors will temporarily house inmates in FSP if they are actively engaging in self-

injurious behavior. Given the least restrictive housing standard though, the counselors will routinely assess if the inmate can be 'stepped down' to another psychiatric unit or even GP.

The jail counselors at TCCC meet every morning at 8:00am to begin their ten-hour shift. The counselors rotate their assignments on a daily basis, which allows them to effectively share the caseload within the jail. As they all gather together during the morning meeting, the counseling supervisors and the administrative staff distribute the individual counseling assignments for the day. The specific counseling assignments are grouped by unit and housing classification, and they are further prioritized by need. Jail standards dictate that most of the psychiatric inmates housed throughout the Health Services Building need to be assessed by the counselors at least every six to eight days. For instance, if a counselor receives the HS-E assignment, then they are responsible for conducting the daily routine mental health assessments for the men housed in HS-E. Furthermore, the counselor with the HS-E assignment can focus on the individuals in the unit who are due for their routine mental health assessment, as opposed to trying to conduct assessments for all fifty-two men in the unit.

At least one counselor will receive the daily "PIC" assignment, which is designated for inmates who meet the criteria for psychiatric intensive care and need to be assessed by the counselors on a daily basis. This includes the men in HS-D, the men in the Visual Check (VC) Hallway, and any of the women in HS-C who also meet the PIC criteria. Beyond the routine assignments throughout the Health Services Building, at least one counselor will receive the daily "Follow-up" assignment which is designated for the inmates housed in GP who have made an official request to meet with a mental health counselor. The deputies

in the GP units can also submit a referral to the counselors if they are concerned about any of the inmates housed there.

After the 8:00am assignment meeting in the conference room, the counselors return to their individual offices in various buildings across TCCC's campus. With their assignment in hand, the jail counselors prepare for their daily caseload by using the desktop computers in their offices. Specifically, they will use their computers to access the various electronic databases (e.g. EHR and Tiburon) and review their patients' files. The typical caseload per assignment is anywhere from twelve to sixteen inmates, and the counselors will spend about two hours conducting their background reviews. As such, the counselors usually begin meeting with the inmates on their caseload by mid-morning. Much like the mental health counselors at Central Booking, the jail counselors at TCCC are conducting their psychiatric assessments with housing determinations in mind. That is, the counselors consider their patients' full mental health histories and current presentations before making their recommendations. For instance, individuals can be "stepped down" to a less restrictive type of cell, or an individual may need to be "stepped up" to a more secure cell where they can be monitored more closely. The counselors usually finish their assessments around noon, and spend the rest of their shift back in their offices typing their notes, updating the inmates' files in the various databases, and making various recommendations.

Not Everyone Can Cope

As the jail counselors conduct their follow-up assessments (CIFRs) at Central Booking, they have the inmates fill out the TCSO Mental Health Screening Form before quickly reviewing their answers with them in person. Then, once the CIFR is complete, the

jail counselors can record their notes and make the appropriate housing recommendations to the corrections staff. Moreover, 'Class' can begin to schedule a timely transfer of the inmates from Central Booking to TCCC.

One morning, I follow Holly and Robin through Central Booking as they work to complete their CIFR assignment. The two jail counselors have decided to begin their follow-up assessments with the men currently housed in Post 2. Specifically, Robin tells me there are a total of thirty inmates in Post 2 with 'open' CIFRs who are waiting to be transferred to TCCC. At 7:45am, I walk with the counselors from their office in Central Booking over to Post 2. They are each carrying a large stack of TCSO Mental Health Screening Forms for the inmates to complete.

When we first arrive in Post 2, Holly and Robin briefly exchange notes with the TCSO deputy who is sitting at the command desk. In particular, they are exchanging information about which inmates still need to complete their follow-up assessments. The deputy then locates the specific cells in which those are inmates are housed, and walks around the Post with his keys to unlock their cell doors. Meanwhile, Holly and Robin have moved over to the tables in the middle of the Post, where they have placed the stack of screening forms and some pencils. There are a total of ten tables in the Post, placed in two rows of five. Each of the tables are rather small, surrounded by six metal stools that are bolted to the floor. As the inmates file out of their cells, they walk over to the tables, where the counselors have them fill out their forms. The deputy regulates how many inmates are out of their cells at any given time, so Holly and Robin cycle through their screening assessments with as many as eight inmates around the tables. Once an inmate completes

their form, they hand it back to the counselors who then quickly read through the responses. The counselors will then either clear the inmate to go back to their cell, or pull them off to the side of the tables to have a subsequent, one-on-one conversation about a particularly concerning response.

After speaking with one of the inmates in Post 2, Holly leaves the tables and walks directly toward the deputy and I standing near the command desk. She says, pointedly, "He's going to FSP, now." The deputy looks across the Post in the direction of the tables, and asks Holly, "Which one?" Holly looks down at her notes, and says, "217," in reference to the inmate's cell number. The deputy then walks over to the inmate, who is sitting on one of the metal stools in a hunched position with his head down. The deputy escorts the inmate over to the command desk, where he is promptly placed in handcuffs and lead out of the Post by another deputy. Once the inmate is gone, Holly walks back over to the tables where she conducts her remaining assessments. As I am stand near the command desk waiting for Holly and Robin to finish, I ask the deputy what they thought about the inmate who was just transferred to FSP. The deputy tells me, "Well, most of the time, the inmates who are in rough shape are going to be like that that down at intake, and they will get sent to FSP from there." As the deputy further explains, "But, yea, sometimes you can't really tell what they are going to be like until they get up here. Usually, they all find ways to cope with being up here. Clearly, not everyone can cope."

Is the Housing Helping?

At TCCC, the jail counselors are also mindful of the potential for inmates' psychiatric presentations to fluctuate over time. In particular, they describe the varied

psychiatric presentations of the inmates on their PIC assignment. As previously noted, the PIC assignment focuses mainly on the inmates in HS-D who meet the criteria for psychiatric intensive care and require daily mental health assessments.

I follow Lucas one morning as he manages the PIC assignment at TCCC. As he works from the computer in his office, and prepares his case notes for the pending assessments, I ask him to describe the typical interaction that he expects to have with the PIC inmates in HS-D. Lucas tells me the PIC assessments are often the shortest mental health assessments, noting two main reasons. In one scenario, Lucas cites the jail's intake protocol for placing inmates into psychiatric observation. Specifically, the intake deputies and counselors will automatically place an inmate into psychiatric observation if the inmate makes a specific threat of harm to self or others, or if the inmate refuses to engage entirely. Lucas notes these instances occur more often among inmates who are severely intoxicated during their intake process at Central Booking. Lucas explains, "By the time these guys are transferred out here, they have time to sober up, and their presentations change. So, they just want to get out of the isolation cell, and the conversation is short."

Lucas says there is also a second scenario in which the brief PIC assessments occur. Specifically, he says, "A lot of the other inmates in PIC are really mentally sick and cannot talk much at all. So, not only are their assessments brief, but they also end up spending quite a bit of time in PIC." Lucas goes on to explain that, as LCSWs and LPCs, the jail counselors can clinically diagnose inmates. Usually, however, they will only conduct their assessment in order to confirm a prior diagnosis or rule out other potential diagnoses. For instance, Lucas posits, "Can we rule out psychosis versus drug-induced mania? You know,

is it biological or substance abuse? And, of course, it could be both. But, going in, PIC is the most acute unit because we are unsure if it is drug-related."

Other jail counselors describe a similar experience with their assessments of the inmates in the VC Hallway. Specifically, counselors note their assessments in the VC Hallway can be rather abrupt. In one instance, I ask Molly if the safety features inside the VC Hallway play a role in this dynamic, especially considering that it is one of the most secure locations inside the jail. As we're sitting in her office, Molly places both of her hands over a stack of files on her desk, and says, "I'm concerned about safety and security, too. Just in a different way than the deputies. All I ever think about is housing. Are the inmates housed where they need to be?" Willa, who is another jail counselor at TCCC, describes a similar approach to her assessments in the VC Hallway. She tells me, "During the assessments, I'll ask them questions like, 'What motivates you to keep going each day? Is the housing helping? Do you have any thoughts of hurting yourself?' And, maybe they don't answer." According to Willa, however, this doesn't change her perspective. As she suggests, "My job is to make sure they're safe, housed appropriately, and getting the treatment they need."

FALLING THROUGH THE CRACKS

In a one-on-one meeting with Jordan, who is a lead counseling supervisor at TCCC, I mention my interest in learning more about whether or not the counselors perceive any tension between the 'task' of providing mental health services in the correctional setting and the 'tools' associated with their autonomy and decision-making power as mental health professionals. Jordan pauses to think, before naming the fact that the jail, as a correctional

institution, is primarily focused on safety and security rather than mental health care. He then goes on to describe what he perceives as a disconnect between the jail and its community partners. In particular, he tells me the jail's community partners don't have a sense of what it means to provide psychiatric treatment and mental health services in a correctional setting. Jordan says, "The community at-large thinks the jail can just take care of it. You know, they'll say, 'Give them a pill.' But treatment best practices don't jive with that." Kevin, who is another counseling supervisor at the jail, provides a similar perspective in a separate conversation. Specifically, he tells me, "We do our best for treatment in the jail, but it's a jail. Is that a therapeutic environment? No, it's not. We can provide some things that inmates might not otherwise engage with in the community, but these are people that are best served by proper psychiatric care."

No Place to Go

I arrive at TCCC one morning just before for the counselors' 8:00am briefing and assignment meeting. As the meeting begins, one of the counselors asks the staff administrator to elaborate on the specific details of the HS-C assignment. The staff administrator, Craig, says, "There are fourteen inmates on the HS-C list today," and he begins to read each of their names aloud. The counselor interrupts him after the third name, and says, "Wait, what is her status?" Adding to the conversation, another counselor says, "When I saw her a few days ago in HS-C, she had large knots on the side of her head from banging it against the wall." Craig looks over to the jail's court liaison, who is also present in the meeting, and asks if he has any updates to share about the inmate's case. The court liaison, Daniel, explains:

> This poor woman. I can still remember the first time I met her. She was on the felony mental health docket. The judge running the docket at the time used to call me, "Mr. Jail." Well, anyway, the judge takes one look at her, and says to me, "Mr. Jail, I cannot send this woman to TDCJ (Texas Department of Criminal Justice)." So, the judge calls a sidebar in the court, and we tried to figure out an arrangement for her. But this was years ago, and even now she has no place to go. None of the psych hospitals will admit her because of her history with self-harm. I mean, her lawyer is trying to get her out of here, or get her placed somewhere. But until then, there is just no place to go.

Daniel offers to reach out to the court again today, but he tells the counselors that he doesn't have any immediate updates to share.

On a separate occasion at TCCC, I sit with Lucas in his office as he gathers the background information for the inmates who are listed on his daily assignment. Lucas tells me he is currently reviewing an inmate who may need court-ordered medication. He notes the inmate is housed in psychiatric observation and refuses to engage with the medical and counseling staff. In order to assign court-ordered medication, however, the jail must first schedule a competency evaluation. Lucas decides to make the request for the competency evaluation, and sends an email to Christine (a lead counseling supervisor) and Daniel (the court liaison). Lucas says, "They are trying to find a bed for him somewhere (in a psychiatric hospital setting), but in the meantime he is just going to sit here in his psychosis."

Later, I follow Lucas to the weekly meeting for all mental health staff at the jail, otherwise known as 'Treatment Team Review' (TTR)[12]. During the meeting, Christine

[12] During TTR, the counselors have the opportunity to address specific issues as a team. The counselors find the TTR format to be particularly useful since they share rotating caseloads.

addresses the email that Lucas sent earlier in the day. Specifically, Christine refers to Lucas' request via email for the competency evaluation, and asks the other counselors for input. Molly adds some recent background from her perspective. She explains that the inmate had been housed in HS-E before attempting suicide by trying to hang himself with a mattress string. When a deputy came into the cell to stop the inmate's suicide attempt, the inmate assaulted the deputy, and the inmate was subsequently housed in an FSP cell in the VC Hallway for over two full weeks. Molly says she eventually made the recommendation to remove the inmate from the FSP cell, stepping him down to Y-OBS instead. Molly recalls the fact that a corrections tactical team was brought in to conduct the transfer, and they engaged the inmate with a specific amount of force in order to restrain him. Specifically, Molly says, "I am very upset they pepper-balled him to get him out of FSP." She tells the other counselors in TTR, "He was so worked up and agitated because he had been in FSP for so long, and that's why I wanted to get him out of there in the first place." The other counselors voiced support for Molly's frustrations, telling her that her transfer recommendation was clear. Bringing it back to the present status of the inmate, Lucas tells the other counselors that he tried and failed to complete an assessment of the patient during his earlier rounds in the day. He brings up the issue of court-ordered medication, and plainly suggests, "He needs a competency evaluation, STAT."

A couple of days later, I follow a different counselor with the PIC assignment. The counselor, Bethany, makes her way through HS-D, conducting the assessments with the inmates in Y-OBS. As she approaches the cell of the inmate noted above, I notice the deputies and corrections staff have used a green marker to write a message on the cell

window. The message says, “Use x-treme caution!” Just as Lucas tried and failed a few days earlier, Bethany is not able to engage the patient and she moves on to the next inmate on her list. After her rounds in HS-D, she laments at the fact that the tactical team had to pepper-ball the patient during his removal from FSP. In response, I comment, “It sounds like it was a tough situation all around.” Bethany asks me, rhetorically, “Yea, what’s worse: staying in FSP or getting violently removed? I don’t know. He has no awareness either way.” She wonders, like Lucas, why the patient has yet to receive a competency evaluation for court-ordered medication and involuntary commitment.

The Inevitable Felony

The practical realities of providing mental health services in the jail are often expressed in skeptical terms. While observing Bethany in another instance, she tells me a story about an male inmate she recently assessed in Y-OBS. Bethany says he had been in jail previously, before getting diverted to Austin State Hospital (ASH) for competency restoration. He spent two months at ASH, and they released him directly into the community with only a paper referral to Integral Care’s drop-in clinic. Bethany says, upon his release from the psychiatric hospital, he walked directly across the street to a convenience store, stole a bag of chips, and was re-arrested. During her recent assessment, she asked him what he needed in that moment upon release from ASH, and he told her that he just needed a place to stay and some food. She reflects to me, “He just wasn’t able to get his basic needs met. Like, he just spent two months at ASH, and they expect him to be able to get around like that?”

Another counselor, Molly, posits during a separate conversation at TCCC, "You would think more people would fall through the crack than they do." Molly sits at her desk, preparing for her daily assignment, and she tells me about one of the inmates on her list:

> I go and talk to him, and he says, 'I just want to get out.' And I say, 'Where are you gonna go?' And he says, 'I got a couple places.' So, he's got a couple bridges that he goes to, and it's like, is that better? We want to protect their rights, but we also make it too hard to commit them.

Molly tells me a similar story about another inmate who has been in and out of jail for the past year. She looks at his arrest record in Tiburon, and tells me that his first charge and arrest was for criminal trespass and criminal mischief – standing in a roadway. Molly describes the inmate's cycle of arrest since then, and suggests to me, "A felony was inevitable." She goes on, "It's sad, because now he is just waiting to be sent to Vernon (state forensic prison)." Molly tells me the deputies will ask her, "Who advocates for these guys?" She says in response, "We try."

While sitting with Lucas in his office one morning at TCCC, he asks me "Has anyone shown you a picture of Mister Gumbo?" He types in the inmate's name[13] into Tiburon, and turns the monitor around so that I can see the screen across his desk. Lucas scrolls through the inmate's arrest record, and notes that Mister Gumbo has been arrested and jailed over one hundred times in the past twenty years. Mister Gumbo is now thirty-eight years old, and each of his arrests and jail bookings are listed chronologically in

[13] Just as I have anonymized the counselors' names, my reference here to "Mister Gumbo" is not the actual reference to the patient. The details associated with this particular aspect of the scene, however, do reflect an actual reference to an actual patient - to whom the counselors had assigned endearing moniker.

Tiburon. Moreover, each entry is accompanied by jail intake's contemporaneous mug shot. Lucas scrolls all the way down to the bottom of the electronic record, and shows me the picture of Mister Gumbo's first mug shot. Then, Lucas scrolls back to the top of the record, and shows me Mister Gumbo's most recent mug shot. Lucas exclaims, "The difference is just striking!" He tells me that Mister Gumbo became addicted to heroin as a young adult and contracted syphilis, which spread to his brain. Now, Mister Gumbo has severe psychiatric symptoms. Lucas pauses while looking at Mister Gumbo's picture, and says, "If only he had gotten treatment back then." Lucas closes Mister Gumbo's profile, but continues searching through Tiburon in order to reference the number of times the other inmates on his list have been arrested. He reads from the computer screen, "Thirty-two times, twenty-eight times, twenty-four times… and here's Mister Gumbo, one hundred nine times."

I ask Lucas if he can tell me more about the charges for which Mister Gumbo is most often jailed. He says, "Mostly city ordinance violations, like trespass. But it also looks like there was a recent assault on a police officer." I ask Lucas if he thinks the City's recent trespass initiative (City of Austin 2019), which rescinded prohibitions on public camping, might have an impact on populations that have a history of cycling in and out of jail. In response, Lucas distinguishes between inmates who have strict psychiatric needs and inmates who also experience substance abuse and addiction. According to Lucas, the latter group has less success when being diverted from the jail. In particular, he reflects on one inmate who told him, "I love heroin more than I love my wife and kids. It's hard for me to admit that, but I'm just being honest." Lucas says he told the inmate, "I can't help you. It's

on you to get clean. This isn't a treatment facility." He explains that, beyond the resource guides provided to the inmates upon their release, long-term wellness is not a priority at the jail. Another counselor, Holly, later summarizes the challenge of working to address inmates' needs. She describes the limits to assessment and contextualizes the role of counselors at the jail. Holly tells me, "We have such a short time to work with them, spending maybe ten minutes with them at their cell and then leaving." Still, she tells me that she tries to help the inmates by providing them with the tools to see things differently, even if it's only during their assessment. She also says, however, "I've given a lot of resources guides, but I have no idea what happens to them. It's up to them to continue seeking help once they're released."

GETTING A WIN

In response to the work-related tensions that manifest in the jail setting, the jail counselors express the need to develop and maintain sustainable professional values. Kevin, who is a counseling supervisor at the jail, explains the issue from his perspective:

> Mental health work in any type of environment can be challenging. But in the criminal justice system, it is even more so. You're hearing from people who are screwed. You're hearing about a lot of different types of trauma, and it's hard to hear about their significant history of trauma all the time. It certainly does impact staffing. Burnout is particularly high, and already there are not enough counselors. It can be very fulfilling, but you have to want to do forensic mental health.

Then, in terms of managing these tensions, I ask Molly to describe her approach as a counselor at TCCC. She acknowledges the limitations in the services that provides, but she says they don't bother her as much as they might bother some other counselors. She tells me, "Other people have come and gone, and they have been more bothered the work. They

say, ‘You guys don’t do anything.’ Well, if you think that, then you definitely shouldn’t be doing this work.” She expands on her point, telling me, “Look, I might not be providing therapeutic counseling, but at least I can try to plant a seed. At the end of the day, we have to think through what we are going to be okay with. What are we here to accomplish?”

The counselors at Central Booking have a similar perspective on the need to develop and maintain sustainable professional values. For instance, Robin tells me:

> I don’t think of my work as therapy or counseling. I’m really just managing crisis. Like, I was happy the other day when I was leaving work, and – when I thought about why – I realized I got a win during my shift. Well, do you know what that win was? I convinced an inmate to switch their cell without fighting the deputy in the Post.

Robin continues to reflect on her work and her role, saying, “It’s possible to build some rapport, but you really don’t get to build a therapeutic relationship at Central Booking. I mean, you can get rapport if you’re lucky.” In response, I ask Robin if she has always had this perspective on getting the small wins. She says, “No, I would not have been happy in this job when I was younger. We get into this work to help people, but the idea that you can do it all yourself is a fallacy. I think that’s something I have learned over time.”

THE WORST OF ALL WORLDS

Despite the development of relatively sustainable work-related perspectives, the jail counselors continue to frame their professional experience as extremely isolating. Moreover, they express specific concerns of liability stemming from their housing decisions, and a general sense of unease with respect to the lack of recourse available to the inmates at the jail. In sum, they feel their work in the jail is situated in, “The worst of all worlds.”

Pawns in the Game

The extent to which the jail counselors concede or maintain their service ideals has 'collaborative implications' for the quality and appropriateness of the services they provide. This dynamic is particularly salient among the jail counselors as they interact with the deputies and other correctional staff when conducting their mental health assessments. For instance, one morning during my observations with Molly at TCCC, we approach a deputy standing at the command desk in HS-E, and the deputy says, unprompted, "Going downhill quick." Molly replies, "What's that about?" She pauses for a response, but the deputy just bows his head in the direction of the VC Hallway, which runs adjacent to the HS-E unit. Molly asks the deputy, "Got any that can come out of lockdown?" The deputy bluntly responds, "No. I got a few who should definitely stay."

In similar example with another counselor at TCCC, Nadine briefs the deputies at the command desk in HS-C before conducting her assessments of the women housed there on the psychiatric unit. One of the deputies points to a name on Nadine's assignment list, and says, "She's right where she needs to be. Here, in HS-C." The deputy recalls that Nadine had recently proposed stepping the woman down to GP. However, the deputy provides his own observation, explaining that the inmate talks loudly to herself and worries the other inmates in the unit. As such, the deputy suggests the inmate should not be transferred to GP anytime soon.

Later that day, I tell Nadine that I am curious about her earlier interaction with the deputies at the command desk. In particular, I ask Nadine to describe how she weighs the deputies' insights pertaining to the mental health status of the inmates. Nadine says, "If

I'm on the fence, then I take what they say into account. But I also try to assess their motivation for providing input." She tells me the deputies in GP deal with a lot of inmates who have behavioral issues, so they will try to push them into the HS building. Nadine further explains, "If a deputy is advocating for removal from GP, is it serving their own interests? Like, if they say, 'Get them off my unit.' Um, okay, why?" Having said that, Nadine says she gives the deputies in the Health Services Building the benefit of doubt, particularly if they are advocating for an inmate's safety – as opposed to stepping the inmate down to a relatively less secure GP unit. Nadine summarizes her point by telling me, "The deputies might not always understand our point of view. But we're all just managing risk."

One of the counseling supervisors, Christine, describes this challenge within the context of TCSO's organizational structure. In a brief conversation following the morning assignment meeting at TCCC, she turns to me, and says, "As Sheriff's Office employees, we experience dual loyalty." In particular, she suggests counselors' connections with inmates are rather constrained by the correctional setting. She expands on her point, telling me, "We're on an island here at TCSO because there is no comparison to our work." She explains how, within the organization, the correctional staff don't really understand the role of the mental health counselors. Moreover, other mental health professionals who work in community-based clinical settings don't really have a sense of what it takes to provide mental health services in the jail.

Sarah, who is a jail counselor at Central Booking, reflects on this dynamic in terms of her relationship with the deputies. Specifically, Sarah recalls a case in which she tried

to step an inmate down from FSP only to have the commanding sergeant on duty intervene. Sarah tells me, “I was just trying to calm the inmate down. I gave him a weighted blanket, which helped a little bit, but the FSP cell was just too much.” Sarah tells me that her interest in helping the inmate was superseded by the sergeant’s interests in security. In sum, Sarah tells me, “It’s like we’re visitor here. It’s their farm, and we’re just camping.” While following Sarah during a separate occasion at Central Booking, she reflects on another instance in which there was a discrepancy between her recommendation and the ultimate decision of the correctional staff. In this instance, Sarah bluntly says, “I’m just a pawn in the fucking game.” Candace, another counselor at Central Booking, provides similar sentiment, telling me, “Safety and security trump everything here. Corrections override a lot of our recommendations.”

Experts on Suicide

Many of these work-related tensions have ‘practical implications’ too, producing specific concerns of liability among the jail counselors. Robin, at Central Booking, reflects on these concerns. Specifically, she recalls a deputy coming into her office early one morning to talk about an inmate who was temporarily placed in an FSP cell overnight. In context, there is a four-hour window at Central Booking – between the time that jail counselors’ night shift ends at 2:00am and when they return for their morning shift at 6:00am – in which the correctional staff are responsible for the housing decisions at intake. Then, each morning, the counselors must review the psychiatric referrals that were made in their absence. Robin tells me the correctional staff typically err on the side of caution. Specifically, she says, “They will throw somebody in FSP overnight just for mentioning

suicide." In this instance, the deputy wanted to know if Robin was ready to move forward with a subsequent housing decision, telling her, "You're the expert on suicide." Robin asks me, rhetorically, "Really? Am I?"

The risk for harm in jail is no secret among the counselors. In a conversation with two counselors at Central Booking, Anna and Lauren express to me that their housing decisions directly influence their sense of liability. While sitting in counselors' office at intake, I suggest to them, "It seems like the housing decisions are a large part of what you all do." Lauren responds to me, saying, "Yea, it's all about that really. And, in my mind, it can be a nerve wrecking responsibility." Anna expands on Lauren's point by telling me there were five suicide attempts at the jail during a two-day period in just the last week. Anna looks at me with her eyes wide open, extends her arms out with her palms up, and says, "It's terrifying! What can you do?" Lauren nods in recognition, and says, "There is so much liability here."

The counselors try to mitigate the risks of harm through their housing practices. In one example, Molly considers the housing status of an inmate in an FSP cell at TCCC. As Molly begins her assessments of the inmates in the VC Hallway, I decide to stand back near the entrance but I can still see and hear all of her interactions. I see her approach the first FSP cell and look through the small window in the cell door. The hear the inmate tell Molly that he wants to pulls his eyes out, and Molly responds that his eyes look swollen. He says he has been hitting his face with his closed fists. Molly tries to ask the patient a few more questions, but he only says, "There is no point in talking." Molly looks down at

her notes, and glances at them quietly for about five seconds. She then moves on the inmate in the next cell.

When Molly is finishes her assessments in the VC Hallway, she returns to the command desk in the HS-E unit nearby in order to discuss her observations with the deputies. She begins by addressing her concern with the first inmate she assessed in the VC Hallway. Molly notes the inmate has been hitting himself in the face, and she tells the deputies, “He said he’s got more work to do on his eyes.” One of the deputies picks up a phone from the command desk, and asks Molly if she can relay this information directly to the Sergeant. Molly takes the phone, and she tells the Sergeant that she noticed the inmate’s right thumbnail had grown long. Specifically, she indicates her concern that the inmate might try to gouge his own eye out. Before handing the phone back to the deputy, Molly suggests the medical staff may be able to clip the inmate’s thumbnail if they can get him into an emergency restraint chair (ERC).

When we get back to her office, Molly begins typing her notes and updating the various records in the electronic database. As she works through each case, she talks to me about certain issues that came up during her assessments. For instance, Molly explains to me the risk of placing an inmate in a relatively unsecure space. Although jail standards dictate least restrictive housing options, the jail counselors must also consider whether or not it’s safe to step an inmate down. Molly says, “When I step an inmate down from psychiatric observation, I have to note everything to justify the move. I don’t want to miss anything.” Molly flips a file on her desk, and begins to review the first patient she assessed

in the VC Hallway. She reads one of her notes out loud, and describes the patient's self-injurious behavior. She looks up, and says, "It's hard. You can't not have him in there."

The jail counselors have to continually balance the liability in their work with the least restrictive jail standards. As Molly succinctly describes to me, "Isolation is typically not good for people. If you really have a serious mental illness, then that type of housing is the worst. FSP is the worst possible thing, but it's what we do." This tension creates a dilemma for the counselors at Central Booking too. For instance, as Sarah recalls, "An inmate was just telling, 'If I wasn't up in jail, then I wouldn't be trying to kill myself.' And yet, that's exactly the type of thing that get you placed in FSP."

In a similar scenario, Robin considers what to do with an inmate who she recently assessed at intake with no psychiatric history, no treatment history, but he is currently charged with a felony and said he would try to kill himself if he had to go to prison. Robin says she asked the inmate if he'll be okay for now, and he told her that he would be okay as long as he doesn't have to go to prison. Robin tells me the thing that worries her the most is that the inmate has two prior suicide attempts. Specifically, he disclosed that he twice drank bleach when he was sixteen years old. Robin talks through the case with Susan, who is another counselor at Central Booking working a separate assignment. Together, Robin and Susan agree that GP is the best housing option for the inmate, but they decide to place him on the jail's radar list - which establishes routine follow ups for inmates in GP. Before moving on to her next intake assessment, Robin tells me, "It's always a dilemma."

I ask Robin to how she manages the tension between the least restrictive housing standards and her own sense of unease related to the potential for harm. She tells me, “You do the best you can do, and then you document the hell out of it. It’s the cost of doing business here.” She gives me an example of an inmate who was diverted from but jail but then died by suicide less than twenty-four-hours after release when he ran onto a highway. Molly, at TCCC, tells me, “Inevitably, if you work here long enough, somebody you talk to, something is going to happen to them.”

The Antithesis of Therapeutic Care

Robin describes the frustrating experience of working with inmates who need therapeutic counseling. Although there are some group programs at the jail, only the inmates who are housed in GP are eligible to attend. That is, the inmates who are housed in the psychiatric observation units are ineligible for such counseling programs. According to Robin, “Some of the inmates just need counseling, but that’s not what I’m doing. Locking people up in an isolation cell under psychiatric observation is the antithesis of therapeutic care.” She explains to the inmates that she can get them placed in the group programs as long as they can stay housed in GP. However, upon reflection, Robin admits to me, “What I’m really saying is, ‘Suck it up, and wipe the tears off your face.’ What kind of advice is that? So, yea, it’s hard to be empathetic in a system that discourages it.”

Robin suggests that many of the psychiatric inmates are quite vulnerable to the loud and traumatic environments within the jail. So, when Robin speaks with her patients at Central Booking, she asks them how they might be coping with their experience. Robin says, “One of the things I know about trauma work is you have to build safety. Well, I can’t

build real safety here at the jail, but I can give resources, and I can help folks plan and communicate." In one example, Robin describes a woman who was upset because she did not like the way the deputies were yelling at her and throwing her lunch bag into the cell. Robin says she told the woman, "Instead of getting immediately upset and frustrated at the deputies, try to explain to them that you're having a hard time with the noise, and that you don't like things being thrown at you. I think even they can appreciate that." Although Robin cannot protect the woman from the triggering environmental factors that exist in the jail, she says, "At least I can try to redirect their emotional response by suggesting a new approach."

At TCCC, Lucas has a similar perspective. He tells me, "On some basic level, we are providing a corrective emotional relationship for our patients. If I can plant a seed, then maybe they will engage with other support services down the road." Having said that, Lucas acknowledges the services he provides in the jail are disconnected at the point of community re-entry. In particular, he says, "It's the most frustrating part of our job, because I cannot help these people outside the walls of the jail."

ANALYTICAL REVIEW

In this chapter, I find jail counselors conduct routine mental health assessments and make subsequent housing recommendations to the correctional staff. I also find there are specific disconnects between inmates' psychiatric needs and the limited services that the jail counselors are able to provide. The jail counselors experience this disconnect as their patients, "Fall through the cracks," but they reconcile these concerns by limiting their service expectations. In particular, they conceptualize, "Getting a win," in terms directly

associated with their service constraints. Despite the development of relatively sustainable work-related perspectives, the jail counselors continue to frame their professional experience as extremely isolating. Moreover, they express specific concerns of liability stemming from their housing decisions, and a general sense of unease with respect to the lack of recourse available to the inmates at the jail. In sum, they feel their work in the jail is situated in, "The worst of all worlds."

In my analysis of these findings, I suggest the jail counselors occupy a boundary spanning role at the periphery of their focal organization (Steadman 1992). The jail counselors have to balance the functions of their boundary role in order to conduct their primary occupational task of assessing inmates at the jail. As organizational boundary spanners, the jail counselors process external information coming into their focal organization, and provide a legitimate response on behalf of their focal organization. For instance, the jail counselors process the Continuity of Care Queries (CCQs) with the Texas Department of State Health Services in order to determine if the inmates at the jail are receiving services in the community. The counselors also provide critical information to the courts and other legal processing entities, particularly as the jail manages the ongoing custody of the inmates. These efforts supplement core organizational strategies inside the jail (Steadman 1992).

The jail counselors' professional autonomy and decision-making capacity is also connected to their primary occupational task of assessing the inmates at the jail. From that point, they make various recommendations to correctional staff, court staff, and other medical and mental health staff at the jail. However, as mental health boundary spanners,

their professional prerogatives are often limited by the structural realities of their organizational role (Scheid 2000; Steadman 1992). In particular, the counselors perceive the jail's standards of mental health services as something less than therapeutic counseling. I find the counselors reconcile this tension by decoupling their service ideals from the practical constraints of their work (Lipsky 2010; Thornton et al. 2012). In doing so, the jail counselors reconceptualize what it means to get a win in their relationships with inmates. Successful engagement with inmates is not measured in terms of therapeutic or medical standards of treatment and care. Instead, the counselors develop an approach to their services that focuses on inmates' safety and mitigating environmental trauma.

These organizational and occupational dynamics have collaborative and practical implications for the jail counselors. In particular, the jail counselors must navigate issues and concerns of dual loyalty (Bloche 1999) to both their organizational counterparts (deputies and correctional staff) and the individuals they serve (the inmates in the custody of the jail). Moreover, as boundary role incumbents, the dynamics of their position manifest as concerns of liability (Scheid 2000) and a sense of frustration with the limited practical recourse available to the individuals they serve in the jail (Fisher and Drake 2007; Lamb and Weinberger 2013).

Chapter 4: Mental Health Services in the Emergent Setting

In this chapter, I describe how EMCOT counselors engage with exclusive referrals for crisis intervention services. Despite their efforts to connect individuals experiencing psychiatric crisis to appropriate sources of care as soon as possible, I find the EMCOT counselors are often constrained by the voluntary nature of the services they provide. They perceive this limitation on their service objective as particularly frustrating, and recognize that it sets them up for, "Other problems down the road." In response to the tensions associated with their clients' voluntary service engagement, the EMCOT counselors reconceptualize their service ideals by viewing crisis intervention as a potential moment in which new patterns of client trust can emerge. However, I find that the EMCOT counselors are also required to manage the expectations of their community partners with rather limited resources. These tensions combine to produce a frequent sense of helplessness among the EMCOT counselors, who perceive their work as being situated, "In between two worlds."

CONNECTIONS TO CARE

The Expanded Mobile Crisis Outreach Team (EMCOT) is operated through Integral Care, which is the local mental health authority (LMHA) in Travis County. EMCOT's main goal is ensuring that individuals in the community who are experiencing a mental health crisis are in a position to receive appropriate treatment and support. EMCOT receives their referrals for crisis service exclusively through the local law enforcement and emergencies services dispatch. Most of the mental health professionals working at EMCOT are counselors (either LPCs, LCSWs, or LPHAs). In addition, the

EMCOT mental health staff includes a licensed Nurse Practitioner (NP). Unless otherwise stated, the ethnographic data in this chapter pertain to my observations with the EMCOT counselors. As I find here, much of their work focuses on the 'connections to care' they provide to their clients upon referral from law enforcement and other emergency first responders.

Community-based Services (EMCOT)

In Texas, there are thirty-nine local mental health authorities (LMHAs) and each have their own distinct catchment area (Texas Department of State Health Services 2020a). Integral Care provides an array of mental health and behavioral health services as the LMHA in the Austin, Travis County area (Integral Care 2020b). For instance, Integral Care has a traditional mobile crisis outreach team (MCOT) that is dispatched upon referral from Integral Care's own crisis helpline (Integral Care 2020c). Integral Care also receives a significant amount of referrals for crisis services from local law enforcement officers and other emergency first responders (Meadows Mental Health Policy Institute 2019). In an effort to manage the high volume of referrals coming directly from these other agencies, Integral Care created the Expanded Mobile Crisis Outreach Team (EMCOT) in 2015. The expansion was initially funded in 2015 through a Transformation Medicaid Waiver (Texas Department of State Health Services 2020b). EMCOT now provides the same crisis services as the traditional MCOT, but receives all of its referrals directly from the emergency services' communications and dispatch.

Law enforcement officers and paramedics in the community (community partners) utilize their own agency's dispatch services to submit direct referrals to the EMCOT

counselors. The referrals from dispatch are then sent to the EMCOT counselors through a pager messaging system. Every EMCOT counselor is connected to this pager messaging system, and they all receive the same page for every referral that is submitted. When the dispatch services send the referral through the pager messaging system, they include pertinent details such as a physical address, the responding officer or personnel on scene, and the priority level of the call. Once the EMCOT counselors receive the page and identify the referral, they coordinate as a team through group text messaging threads to respond as quickly as possible.

In order to reduce response times, EMCOT counselors are based in two separate sites across town. In the southern region of Austin, the EMCOT counselors are based in an office that is located inside Integral Care's Dove Springs community-based mental health clinic. In the northern region of Austin, the EMCOT counselors are based in an office that is located inside the Austin State Hospital (ASH). EMCOT shares the ASH office space with two Crisis Intervention Teams operated by the Austin Police Department (APD) and the Travis County Sheriff's Office (TCSO), respectively. The EMCOT counselors utilize a small fleet of unmarked Jeep vehicles for all travel purposes to and from the physical location of the referral.

In order to determine the appropriate level of care for their clients upon referral, the EMCOT counselors utilize the Adult Needs and Strengths Assessment (ANSA), which is a standard assessment tool for counselors in the field (Texas Department of Health and Human Services 2020). Based on the ANSA results, the counselors can recommend a course of action to their community partners and clients. EMCOT works with multiple

psychiatric and behavioral health agencies in the area, and they coordinate the availability of services in real time through Integral Care's Utilization Management (UM) division. Service connections include access to psychiatric emergency medicine at local hospitals, as well as voluntary 'respite' options at various short-term mental health treatment facilities. Many of the clients that EMCOT serve are also "duplicated," which means they are already listed in Integral Care's network as a service recipient. In such cases, the counselors can work to reconnect or reintroduce the client to their treatment or care plan.

EMCOT counselors do not provide case management services. Instead, they work to connect their clients to other sources of more sustained care if and when appropriate. Then, once that connection is made, the EMCOT counselors will 'close' their crisis services to their clients. Sometimes these connections are rather immediate, and the EMCOT counselors can close the referral the same day it is submitted. However, there are instances in which the EMCOT counselors do not make an immediate connection for their clients in crisis, and they will provide follow-up services for up to ninety days. Given this approach, the EMCOT counselors fill one of two types of daily shifts. Most of the EMCOT counselors are assigned to work the 'emergent' shifts, in which they respond directly to the referrals from law enforcement and emergency services dispatch. Otherwise, in a 'routine' shift, the counselors are providing the ninety-day follow-up services to clients in the community, working to 'close' them out.

For each emergent referral, the EMCOT counselors have to complete essential paperwork and update various records within Integral Care's electronic database. Importantly, they are required to complete their notes for each referral within twenty-four

hours of response. This ensures that the notes per service recipient are up-to-date incase another emergent referral is made for the same individual within a relatively short period of time. The 'essential' notes include the EMCOT counselors' narrative of their interactions with the service recipient. The narratives may include specific descriptions of the risk of harm, and the clients' stated feelings and emotions in the crisis setting. Other essential notes include the ANSA results and specific details about the type of service connections, which are necessary for Integral to track EMCOT's billing records. These essential notes for each referral can take as long as two hours to complete.

The EMCOT counselors only coordinate voluntary services with their clients. That is, the EMCOT counselors cannot and do not force their clients into particular treatment options. The EMCOT counselors do, however, work closely with APD and TCSO law enforcement officers who can order specific 'Peace Officer Emergency Detentions' (POEDs or EDs)[14]. According to Chapter 573 of the Texas Health and Safety Code, an individual who presents to law enforcement as an active threat of harm to themselves or to others can be detained without a warrant and involuntarily admitted to a psychiatric emergency room on a temporary basis. In Texas, only law enforcement personnel with specialized training, such as a mental health officer (MHO), can order these involuntary

[14] 'Peace Officer Emergency Detentions' (POEDs) are also referred to as 'Peace Officer Emergency Commitments' (POEC). The colloquial term is simply 'ED'. Importantly, EDs are different than 'Orders of Protective Custody' (OPCs) which are written by medical doctors in the hospital setting, perhaps even to extend a temporary ED. OPCs can also be used to involuntarily remove an individual directly from the community, but it is relatively rare compared to the standard use of the ED.

detentions. Prior to ordering an ED, however, law enforcement in the area will often submit a referral to EMCOT and ask for their clinical assessment of whether or not an ED is warranted or necessary, or if there are other service options available to the individual experiencing crisis. Technically, the EMCOT counselors will not tell the officers what they should or should not do in terms of the ED. They will, however, tell the officer if an individual meets the clinical criteria for ED.

Community Partnerships

As previously noted in Chapter 3, Texas lawmakers passed S.B. 1849 during the 84th state legislative session (Sandra Bland Act 2017). S.B. 1849, otherwise known as the "Sandra Bland Act," required the Texas Commission on Jail Standards (TCJS) to update minimum jail safety standards and diversion protocols. Additionally, the law required the Texas Commission on Law Enforcement (TCOLE) to implement new training standards for all law enforcement officers working in the state. As of May 2018, all law enforcement officers in the state now receive a minimum of forty hours of crisis intervention and mental health training. Compared to the old minimum of sixteen hours, these new standards more than doubled the training requirements.

In an effort to meet the new training standard, various local law enforcement agencies in the Austin, Travis County area have partnered with EMCOT and Integral Care. In particular, the EMCOT counseling supervisors participate regularly in trainings with law enforcement deputies from TCSO and APD. One of the counseling supervisors, Patricia, tells me, "The legislature required all law enforcement to receive the specialized mental health training after Sandra Bland. And not just the new recruits. The current

officers have to complete the training too." Patricia adds, "From my perspective, it benefits everyone. And that includes us." She says the trainings give EMCOT an opportunity to increase their presence and connections with local law enforcement personnel. Patricia tells me, "At the very least, we can meet them where they're at."

The City of Austin recently engaged with a series of policy recommendations following a 2018 report filed by the Office of the City Auditor (City of Austin 2018; Meadows Mental Health Policy Institute 2019). According to the City Auditor, "Since 2008, the Austin Police Department (APD) reported a 95% increase in mental health-related calls. From 2014 through 2017, these calls accounted for about 7% of all calls for service" (City of Austin 2018). Given this background of service demand, the City Auditor summarized specific gaps between a best practices approach and APD's own practices when responding to mental health-related calls (City of Austin 2018). Subsequent recommendations to the City of Austin are based on the following goal: "To equip first responders with the tools and resources needed to connect a person in crisis to the appropriate clinical care as quickly as possible while resolving the crisis safely" (Meadows Mental Health Policy Institute 2019). The recommendations focus, in part, on APD's effort to sustain – if not expand – its relationship with EMCOT. Now, in addition to engaging with APD's training academy, EMCOT and APD have expanded their connections to include real-time telehealth crisis services (Integral Care 2019).

A Perfect Call

I ask Polly, an EMCOT counselor, to describe her role as a mental health professional who works in close coordination with law enforcement officers and other

emergency first responders. Polly pauses for a second, and says rather succinctly, “The police provide protection, and we provide connection.” Nick, who is also an EMCOT counselor, similarly explains, “I just want (the clients) to get the help they need, and the emergent referrals allow us to be present for our community partners too. A warm handoff (from the Austin Police Department or the Travis County Sheriff’s Office) is better than no handoff, for sure.” The EMCOT counselors’ role in providing connections to care is made possible by their own connection to these external systems of law enforcement and emergency response.

While conducting a ride-along with Lou, who is an EMCOT counselor, I observe what he refers to as, “The perfect call.” It’s Friday morning in late March, and Lou receives a page from APD just after 11:00am. He reads the information coming through his pager, and tells me that he recognizes the location and address of the referral. He says, “We’ll get called out to this location every now and then. It’s low-income housing, and a lot of indigent folks live there.” After about ten minutes in vehicle transit, Lou and I arrive on the scene of the referral. Lou parks the unmarked EMCOT Jeep directly behind the APD squad cars in the parking lot of the apartment complex. I follow Lou as he gets out of the Jeep, and we enter the main building of the complex together. The officer who sent Lou the page greets us as we walk into the first-floor lobby. Lou introduces me to the officer as they shake hands. He tells me that he is a mental health officer with APD, and they have worked together on previous calls.

The officer takes a few minutes to give Lou the background information related to this particular case. He tells us the client is a woman who is meeting with a certified peer

specialist in her apartment. At some point during the meeting, the woman expressed suicide ideation to the peer specialist, who then called 9-1-1 with their concerns. However, when the APD mental health officers arrived on scene, the woman indicated that she just wants to hurt herself for the purpose of release rather than actually wanting to die by suicide. Moreover, the officer tells Lou that the woman clearly indicated a specific aversion to going to the hospital. The officer tells Lou, "She says she doesn't want to go to the hospital because she doesn't like the smell of bleach." Given these details, the officer makes the distinction between suicide ideation with and without a plan or intent. As such, the officer decides the woman does not need meet the criteria for ED. The peer specialist, however, disagreed. As such, the officer tells Lou that he made the referral to EMCOT in order to see if anything else can be done.

After getting the background information about the case from the officer, Lou goes upstairs to meet with the client. Meanwhile, the officer and I stand in the hallway outside the apartment. After about thirty minutes, Lou comes out and clears the call with the officer. He says the officer was correct in that an ED was unnecessary, suggesting, "(The client) does not need to be hospitalized, especially against her will." Moreover, Lou tells the officer that he was able to alleviate the peer specialist's concerns by putting a safety plan in place with the client. When we return to the Jeep in the parking lot, I ask Lou what he thinks about his resolution to the referral. In response, he suggests the peer specialist was right to be concerned about the client's safety and call 9-1-1. And, upon referral, Lou says he was able to accomplish some safety planning with the client that the officer wasn't trained to do. Lou tells me, "It was the perfect call."

OTHER PROBLEMS DOWN THE ROAD

In the context of EMCOT, the primary concern among the mental health counselors is related to leaving their clients in the community without any formal or immediate connections to care. While shadowing Nick on an emergent shift, he shows me a text message that he just received from another counselor, Daniel, who is responding to a separate referral. Daniel provides an update to the team, writing, "It was quick. Client just wanted to get on with her day." After showing me the message, Nick starts to tell me about the challenge of engaging with clients in the community and relying on voluntary services. He describes a disconnect between the intent of broader policy initiatives and EMCOT's services on the ground:

> The whole point of the Sandra Bland Act was to get people connected to services, to require faster services in jails, to train law enforcement, and for mental health emergency services to expand. But from EMCOT's perspective, it doesn't really pan out because a lot of what we offer is voluntary. Our clients can, and often do, refuse to engage.

In another brief illustration of this point, Catharine tells me about a recent crisis referral from TCSO. As Catharine describes, "When I arrived on scene, the client says to me, 'Can I have your card?' So, I hand my card to the client, who then says, 'Okay, you can leave now.' Well, crap." Another EMCOT counselor, Martin, suggests the counselors' concern goes well beyond navigating immediate connections with their clients in the community. Martin references a hypothetical referral in which a client voluntarily goes to a respite facility. He says, "The challenge is that many of those services are so short-lived. It sets us up for so many other problems down the road."

Rene, who has been working as an EMCOT counselor since the program began in 2015, recounts a more recent referral from APD. In this case, APD was responding to a 9-1-1 call related to a disturbance at a local sandwich shop on the north side of town. An APD mental health officer (MHO) responded to the call, and made a subsequent referral to EMCOT. Rene tells me that the client was not under arrest, broke no laws, and was not a danger to self or to others. Rene tells me that when she arrived on the scene of the referral, she engaged with the client in the parking lot of the sandwich shop, but the client just kept talking in circles for over two hours. She says to me, "People like that are exhausting. You try to redirect, redirect, redirect, and you hope to get a plan and some follow through." Eventually, Rene was able to convince the client to go to the psychiatric ER in downtown Austin on a voluntary basis. However, she says was skeptical of whether or not the client would engage with the psychiatric clinicians in the ER. In particular, she was concerned about the prospects of care after the client said he had been off his psychiatric medication for over a year. Rene says, "Gotta just hope the client gets back on their meds or sees a practitioner at some point. Otherwise, we're just throwing him from one side town to the other. It's tough. Those are the most frustrating calls to me because what did we really accomplish?"

Reflecting on the voluntary nature of EMCOT's services, Minnie, who is one of the counseling supervisors at EMCOT, describes a referral from APD that she received earlier that same day. Minnie tells me that, after she arrived on the scene and conducted her assessment, it was her clinical judgment that the client met the criteria for emergency detention (ED). However, the MHO, who was also on scene with APD, did not agree. In

terms of the decision to order an ED, Minnie explains to me that the MHOs make their own determinations with or without – and sometimes even against – the recommendation of the EMCOT counselors. From Minnie's perspective, "The client was entering dangerousness. And that's my biggest frustration, because I see people that are going to end up in jail. But, I can't ED." Later in her shift, Minnie says she received a notice from APD that the client had in fact been detained and taken to the psychiatric emergency room. Minnie describes feeling vindicated, telling me, "I guess the officers got enough calls out there that they ended up having to take the client in. Could have avoided all that. Someone entering dangerousness shouldn't necessarily be left out in the community."

I ask Minnie if these situations apply to well-known legal cases such as Tarasoff[15]. Minnie explains that the Tarasoff 'duty warn' doesn't necessarily apply to counselors working in Texas. Specifically, she says, "Although we have a duty to warn officers, we do not have a duty to warn other individuals in the community." For example, if Minnie determines upon assessment that a client meets the criteria for ED by presenting an imminent threat to themselves or to others, then she has a responsibility to relay that information to law enforcement personnel. However, the duty to warn and the power to order an ED in Texas remains with law enforcement personnel.

[15] In 1976, the California Supreme Court ruled that mental health professionals have a duty to other individuals in addition to their own patients. Specifically, the court ruled, "The public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins" (Tarasoff v. Regents of the University of California 1976).

While shadowing Daniel in the field, he receives a page from EMS dispatch services. Daniel checks the GPS on his phone and identifies the location of the referral as a residence in a neighborhood nearby. After confirming the location, he calls the number from dispatch, and tells the EMS personnel that he is ten minutes away from the scene. When we arrive on scene in the unmarked Jeep, I notice there are two APD squad cars and an ambulance parked on the street. An EMT walks over to Daniel and I as we get out of the Jeep, and gives us some additional background about the referral. Specifically, the EMT says the client is a sixty-seven-year-old woman who is experiencing a manic episode inside her home. The client's daughter, who also lives in the home, is the individual who called 9-1-1 for help. The EMT says that APD and EMS both arrived on scene, but APD deferred the scene to the medics, who eventually made the referral to EMCOT. The EMT says the woman is not currently a danger to herself or to others, so an ED is not really under consideration at this time. However, according to the client's daughter, the client hasn't slept in four days and is not eating. After providing this background, Daniel follows the EMT into the home to conduct his own assessment.

Forty-five minutes later, Daniel emerges from the home with the EMT and the APD officers. They all talk briefly on the sidewalk outside of the home, before returning to their respective vehicles. Daniel steps into the Jeep and tells me, "That was anticlimactic. Can't get somebody help if they don't want it and they're not dangerous." He says the daughter was hoping to get her mother hospitalized. Upon assessment, Daniel tells me, "The client presented with rapid tangential speech requiring frequent redirection. That is a clear sign of mania." However, the client was refusing to go to the hospital and didn't meet the criteria

for ED. Daniel says, “That was hard to hear for the (client’s) daughter. I told her that it is probably going to get worse before it gets better. I suggested that if it gets to the point where it’s been six or seven days without sleep, then she should call again.” According to Daniel, he gave the daughter a recommendation to request an MHO from dispatch next time, as opposed to request EMS or standard police. Daniel says, “At least I was able to provide some information to the family about how to go about it.” I ask Daniel about the conversation that he had with EMS and APD on the sidewalk after they came out of the home. Daniel says, “I told APD they were probably going to get another call from the family.” As we ride back to the EMCOT office located inside the Austin State Hospital (ASH), I ask Daniel to describe how he feels when he leaves a client in the field without a formal connection to care. He tells me, “It’s frustrating. It's always hard when you drive away. But, what can you do? You can’t hold somebody against their will. It's not illegal to be deteriorated. It's not illegal to be psychotic or, at least, very manic.”

EMPATHETIC LISTENING

In the section above, Rene describes her frustrations with getting clients to voluntarily engage with EMCOT’s services. In an effort to deal with these frustrations, Rene explains to me that it is important to keep a ‘heroes versus helpers’ mindset. She says, specifically, “We’re not heroes, and we can’t try to be heroes. Instead, we’re helpers. We are here to help the clients help themselves, but we can’t do it for them.” Rene tells me that some counselors try to be heroes when they first start with EMCOT. She says, “They try to be Superman. They think we are here to save lives.” I ask Rene if her own perception has changed over time. In response, she tells me, “Yea, but it’s not about me being jaded

or anything like that. It's just a matter of having realistic expectations. For instance, I know that if I can give someone hope, then that's the best thing I can do." I ask Rene to tell me more about how she tries to instill hope in her clients. She explains that it's more than just connecting clients to services. Rene says, "At EMCOT, there is a large role for patience and listening. It's our belief that we need to talk *with* the client and listen to them in order to meet them where they're at, in their reality." She refers to this approach as 'empathetic listening' and calls it, "The art of what we do." Rene tells me that empathetic listening involves showing clients an openness to being present and intentional. Although she admits certain clients are, "Exhausting," like the one she previously referenced, Rene says it's important nonetheless to maintain an appropriate disposition when she's meeting with them in the field.

Ned, who is another counselor at EMCOT, describes a similar approach as we sit and wait for referrals during his emergent shift. In particular, I ask if Ned thinks his work is complicated by the voluntary nature of the services he provides. Like Rene, he also admits, "Yea, it can be frustrating." Ned quickly adds, however, "But we don't want to drag the client anywhere. Like, even if we don't connect the client to services that day, the hope is that we can plant a seed." Ned explains that he often has to work through his clients' own barriers, including their distrust of law enforcement and medical systems. He says that his reliance on the provision of voluntary services can help to facilitate the trust that is necessary to break down those barriers. Ned tells me, "It's about being hopeful that a new pattern can emerge after a moment of crisis. It's hard, but I just tell myself to slow down. I can't do everything in one assessment."

IN BETWEEN TWO WORLDS

Despite reconceptualizing the issues associated with their clients' service engagement, I find that the EMCOT counselors still have to manage various organizational expectations with rather limited resources. These tensions combine to produce a frequent sense of helplessness among the counselors, who perceive their work as being situated, "In between two worlds."

This Little Badge

While shadowing Tessa in the field one day, she reflects on a larger issue that she has with the referrals for crisis services. According to Tessa, many of EMCOT's community partners will submit referrals to EMCOT knowing that the counselors probably cannot do much for the clients on the scene. She tells me, "I feel like I'm in between two worlds, and I don't have power in either of them. I feel like we get it all thrown on us."

I talk with Rene about her perspective on this issue, particularly since she has been with EMCOT since the program started. According to Rene, when the paging system first went live in 2015, EMCOT received most of their referrals from EMS. Rene tells me that many of the APD officers were apprehensive about making referrals to EMCOT. In particular, Rene tells me, "Cops like to control their scene. They don't like to wait around for twenty or thirty minutes for EMCOT to arrive because they feel like (the scene) can get away from them." However, Rene says that APD was getting a lot of pushback from the jail about arresting people for things like criminal trespass. She says, "Now, they are starting to see jail as a last resort, and most of our referrals come from APD."

I ask Nick to describe his view on the relatively large number of referrals from law enforcement, and he tells me, “The officers are starting to recognize that we are a resource. So, yea, it’s no surprise that they are utilizing us more.” I observe many instances of this dynamic while shadowing the EMCOT counselors. In one example, Catharine receives a page from APD with a crisis referral for a young man in his early twenties. The young man’s grandmother is concerned about the client’s safety, and called 9-1-1. When Catharine and I arrive on the scene of the referral, the officer admits upfront, “We don’t have anything. Can’t ED right now.” The officer continues to provide more background information, explaining:

> The subject refused EMS, so I suggested we call EMCOT. I told the him, ‘They’re the mental health experts.’ The subject responded with concern about being taken to the hospital, and I told him, ‘If anybody is going to put you there involuntarily, it’s going to be the police. But EMCOT can come and help you safety plan.’ He thought that was okay, so we called you.

Catharine meets with the client for over eighty minutes inside his home. When she returns to the EMCOT Jeep after the assessment, I ask Catharine how she felt about the officer’s approach to the referral. Catharine tells me, “Oh, it was great. It’s nice to know that officers are indicating our services are strictly voluntary.”

When Catharine and I return to the EMCOT office located inside ASH, she starts to work on her essential notes. I ask her, “So, was that a successful call?” She nods her head to the side, and says, “Well, no. I would have liked for him to go to the hospital, but he refused. I don’t really feel great about his safety plan either, especially because he doesn’t have immediate access to psychiatric care or treatment.” I ask Catharine to describe how she feels leaving him in the community despite the safety risk, and she tells me, “In a

perfect world, we might all have this figured out. But what can you do for the clients in these cases? An ED is going to be counterproductive. We don't want to lose his trust." Steve, who is another EMCOT counselor working in the office, joins the conversation. He tells me that his clients are often concerned that they are going to be committed to a psychiatric hospital. Steve lifts the ID attached to the lanyard around his neck, and says, "But this little badge doesn't give me the authority to do that."

Resource Management

In addition to balancing the expectations of their community partners and the assumptions of their clients, I find the EMCOT counselors have to manage the allocation of specific resources in the emergent setting. For instance, while sitting with Ned and Rene in the EMCOT office at the Dove Springs clinic, Ned tells me that it can be hard to consider which resources might be available for a particular client. He describes how many of EMCOT's community partners have conflicting policies, which in effect excludes certain clients from receiving services. For example, Ned says that many of the psychiatric hospitals in town will not accept clients who have known medical complications, such as various respiratory issues. The issue for EMCOT is that many of their referrals come from EMS, who often provide vital examinations by default. Rene agrees, and tells me that sometimes she has no idea what to do in a situation. However, she adds, "The hardest thing is when I *do* know what to do, but the funding isn't available. Before we can do anything, we have to call UM and see what's available. They pull the purse strings for the hospital and respite beds."

I present the following observation with Nick, Tessa, and Polly, who place this dynamic in sharp relief. While sitting Nick and Tessa in the EMCOT office at the Dove Springs clinic, a page comes in from TCSO. Tessa calls the telephone number listed in the message from the pager, and she connects with a deputy from TCSO Crisis Intervention Team (CIT). The deputy tells Tessa that he submitted a referral to EMCOT because he is meeting with a client who is currently in the custody of the jail. The client is set to be released in four hours, and has indicated an openness to getting treatment at a respite facility. Tessa tells the deputy that she will have to ask Utilization Management (UM) about their current availability. However, she says it might be best if she checks with UM closer to the time of the client's release, especially since resources and funding are subject to change throughout the day. The deputy asks Tessa to call him back in a few hours so that he can discuss availability with the client before he gets released. She agrees to call him back, ends the call. She turns to me and Nick, and tells us that she usually waits to call UM until a client is ready to be transported – regardless of whether or not they are coming from inside the jail or out in the community. Tessa says, "I don't want to make any false promises to the clients." Nick agrees, and says he does that too. Specifically, Nick says, "UM can be coy with hypothetical funding scenarios. They'll say, 'We can't hold any beds for you.' Well, sometimes it's not about holding beds. It's about understanding current options before we go in and talk with a client about what we can provide."

A few minutes after Tessa's conversation with the TCSO deputy, Polly walks into the office and takes a seat. Polly takes a deep breath and says, "I was supposed to be done with my shift an hour ago. She grabs a mint from the bowl sitting on the table in the middle

of the office, and says, “I haven’t had any food since I started my shift at 6:00am.” She tells Nick and Tessa that she just completed a referral that lasted for six hours. According to Polly, although the client was willing to get voluntary treatment at respite facility, “The issue was funding. Nobody had an open bed in respite.” She says there were a few beds available at one facility, but they were being reserved for EDs only. Polly says the client was even open to the ED, but then they spent three hours just waiting for the MHO to come. She says, “It was hard. I was starting to get that feeling of helplessness.” When a respite bed eventually opened up, Polly says, “I cancelled the MHO, who never showed up anyway, and I drove the client over to the respite facility myself.”

Always Be Closing

When the EMCOT counselors describe their referrals that last for multiple hours, they also reference the need to maintain healthy boundaries with their work. In particular, they often allude to their ‘Always Be Closing’ (ABC) practices. The ABCs are a reminder to focus on solutions or end points with their clients. To explore this practice, I point to an exchange with Catharine at the EMCOT office located in ASH. Daniel is also in the office preparing to begin his routine shift. As he gathers his notes at his desk, Catharine asks him, “Have you been on any interesting calls lately?” Daniel responds, “They’re all interesting, but I recently had a few marathon calls.” He goes on to reference a client who was manic and couldn’t decide whether or not she wanted to go to a respite facility. Daniel says, “She couldn’t make up her mind. She just vented for two hours.” Catharine reminds Daniel to keep the ABCs in mind, and asks him about the clients he is scheduled to see during his routine shift later today. He shows Catharine the notes that he has prepared for each client.

She points to one of his notes, and says, “She might take a while.” Catharine recognizes the client as ‘high utilizer’ from previous referrals. She hands the notes back to Daniel, and says, “Seriously, she’ll talk your head off.”

Minnie reflects on this dynamic, and she explains that she is not surprised when clients have nowhere else to turn. She tells me, “I think it’s patronizing what we offer.” I ask Minnie to clarify, “Who is ‘we’? Are you talking about EMCOT?” She says, “Yea, EMCOT and the entire way the mental health system is set up. Most of our clients are never in a position to get the care they need.” Similarly, Catharine acknowledges, “Medicine can help folks if they are experiencing severe psychosis. But with depression and some other things, people need support in other ways. They need a different kind of connection than what offer.” The EMCOT counselors recognize that much what the emergent setting requires is beyond a strict medicine-based approach to treatment. In this view, the counselors’ ABC practices are part of their balanced approached to being a ‘helper’. As Rene mentions in the previous section, the helper mindset isn’t about being jaded. Instead, it’s about having realistic service expectations.

ANALYTICAL REVIEW

In this chapter, I describe how EMCOT counselors engage with exclusive referrals for crisis intervention services. Despite their efforts to connect individuals experiencing psychiatric crisis to appropriate sources of care as soon as possible, I find the EMCOT counselors are often constrained by the voluntary nature of the services they provide. They perceive this limitation on their service objective as particularly frustrating, and recognize that it sets them up for, “Other problems down the road.” In response to the tensions

associated with their clients' voluntary service engagement, the EMCOT counselors reconceptualize their service ideals by viewing crisis intervention as a potential moment in which new patterns of client trust can emerge. However, I find the EMCOT counselors are also required to manage the expectations of their community partners with rather limited resources. These tensions combine to produce a frequent sense of helplessness among the EMCOT counselors, who perceive their work as being situated, "In between two worlds."

In my analysis of these findings, I suggest the EMCOT counselors occupy a boundary spanning role at the periphery of their focal organization (Steadman 1992). The EMCOT counselors have to balance the functions of their boundary role in order to conduct their primary occupational task of assessing individuals in crisis and connecting them to care. As organizational boundary spanners, the EMCOT counselors process external sources of information coming into their focal organization. Moreover, they provide a legitimate response on behalf of their focal organization. For instance, the counselors field referrals from multiple community partners, and they work with law enforcement officers and other emergency first responders to verify the extent of the active risks in the crisis setting. The counselors also provide resources to their clients by connecting them to care and helping them to safety plan in the community.

The EMCOT counselors' professional autonomy and decision-making capacity is connected to their primary occupational task of assessing individuals experiencing psychiatric crisis in the community. From that point, they make various recommendations to their clients and community partners in the emergent setting. However, as mental health boundary spanners, their professional prerogatives are often limited by the structural

realities of their boundary role (Scheid 2000; Steadman 1992). In particular, the EMCOT counselors struggle with engaging their clients on a voluntary basis, and they often lack the legal standing to do anything about it. I find the counselors reconcile these tensions by decoupling their service ideals from the practical constraints of their work (Lipsky 2010; Thornton et al. 2012). In doing so, the counselors reconceptualize what it means to connect with individuals in crisis. That is, successful service engagement is not measured in terms of some connection to standard care. Instead, the counselors develop a more wholistic and empathetic approach to engagement that focuses on building trust.

These organizational and occupational dynamics have collaborative and practical implications for the EMCOT counselors in the emergent setting. In particular, the counselors have to navigate concerns of being professionally isolated, or otherwise burdened, by their boundary spanning role (Steadman et al. 2016). They view their law enforcement counterparts as throwing referrals onto them with unrealistic expectations. Moreover, as boundary role incumbents, the dynamics of their position manifest a sense of helplessness, particularly as they manage limited resources across a client population with needs far beyond the parameters of their own services (Fisher and Drake 2007; Lamb and Weinberger 2013).

Chapter 5: Mental Health Services in the Re-entry Setting

In this chapter, I describe how ANEW case managers provide mental health services to individuals on probation and parole. I find the ANEW case managers' service objectives often blend with the technical terms and requirements of their clients' justice supervision. In an effort to balance this dynamic for their clients, the ANEW case managers emphasize the, "Shades of grey," that various technicalities overlook. For instance, the ANEW case managers work to validate their clients' trauma and extreme vulnerability. Despite these adjustments to their service perspective, other organizational pressures continue to limit their view of work-related success. The ANEW case managers frame these sustained pressures as, "The need to feed the beast."

CASE MANAGEMENT

The ANEW program is operated through Integral Care (Integral Care 2020a). ANEW's main goal is ensuring that individuals on probation and parole receive targeted mental health treatment services in the community. ANEW receives direct referrals for case management from Travis County Adult Probation and the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), which is a division of the Texas Department of Criminal Justice (TDCJ). ANEW's mental health staff includes a licensed Psychiatrist, and many of the case managers are either LPCs, LCSWs, or LPHAs. However, some of the case managers working at ANEW are not professionally licensed counselors. The ANEW case managers conduct routine mental health assessments, and support their clients by introducing them to specific behavioral and emotional learning skills and connecting them to other socioeconomic resources in the community. Unless

otherwise stated, the ethnographic data in this chapter pertain to my observations with the ANEW case managers. As I describe below, much of their work focuses on 'case management' in coordination with their justice counterparts.

Community-based Services (ANEW)

The ANEW program at Integral Care is funded through service contracts with both Travis County and TDCJ. As such, the ANEW program receives direct referrals for case management from TCOOMMI parole services and Travis County Adult Probation. Individual referrals are initiated prior to a client's release from prison or jail. Then, ANEW works to schedule the client's intake appointment within ten to fifteen days of their release from correctional custody. The ANEW program provides community-based mental health and behavioral health treatment services to their clients on the specialized caseload.

ANEW's main clinic is located on the ground floor of the Travis County Adult Probation office building in Austin, TX. The clinic covers one-half of the building's ground floor, while the other half is covered by probation. Before entering the clinic's reception area, clients and visitors must pass through a metal detector and security checkpoint, which is staffed by law enforcement personnel. After passing through security, clients and visitors must check in with the administrative staff located behind the counter in the reception area. The administrative staff then relay the arrivals to the case managers, who each have their own office in the clinic. Beyond the reception area, the offices are all located in a long corridor that requires key access.

ANEW also has two offices inside the Austin Transitional Center (ATC), which is a residential transition center located in southeast Austin, TX. ATC is comprised of two

large one-story buildings. The facilities at ATC are operated by CoreCivic, which is a private correctional management company formerly known as Corrections Corporation of America. The ATC contract is with both TDCJ and Travis County. On an average day, there are over four hundred residents living at ATC, nearly one-quarter of whom are on ANEW's caseload. Most of the residents are on parole from TDCJ. The ANEW offices at ATC are located inside the main building's administrative section, which requires key access. A team of TDCJ parole officers also have their own office space inside ATC.

In order to determine the appropriate level of care for their clients upon referral, the ANEW case managers utilize the Adult Needs and Strengths Assessment (ANSA), which is a standard assessment tool for counselors in the field (Texas Department of Health and Human Services 2020). However, ANEW's reimbursement and billing standards are associated with the assessment tools of their justice partners. Officially, ANEW defines their services according to the Texas Risk Assessment System (TRAS), which is a modified version of the Ohio Risk Assessment System (ORAS). These assessment tools are used by criminal justice organizations because they account for criminogenic needs. Instead of using these tools, however, the ANEW case managers apply their client's ANSA risks scores to the three risk levels on the TRAS. Low-risk clients are assigned to 'Continuity Case Management' (CCM), and they meet with their case manager for a minimum of one hour every month for three months. Moderate-risk clients are assigned to 'Transitional Case Management' (TCM), and they meet with their case manager for a minimum of two hours every month for twelve months. High-risk clients are assigned to 'Intensive Case

Management' (ICM), and they meet with their case manager for a minimum of four hours every month for twenty-four months.

The ANEW case managers have to balance their schedule to account for three types of meetings. This includes intake assessments for new clients, and case management and crisis management meetings for current clients. During the meetings with their clients, the ANEW case managers review current diagnoses, psychiatric evaluations, and medication lists. Whereas diagnoses and psychiatric evaluations are valid for twelve months, the clients' medication lists can vary by month. The ANEW case managers also support their clients by introducing them to specific behavioral and emotional learning skills, and connecting them to other socioeconomic resources in the community. The ANEW program also has a weekly series of group counseling sessions with topics on anger management, coping with stress, balancing emotions, relapse prevention, and seeking safety.

After meeting with their clients, the ANEW case managers also share specific updates with the community partners in probation and parole. For instance, clients who miss their scheduled appoints are labelled, "No shows," and clients who miss three scheduled appointments in a row are at risk of early closure. The ANEW case managers will relay this information along with clients' diagnoses and medication lists. However, there are certain limits to what the ANEW case managers can share and how they share it. For instance, the ANEW case managers are required to encrypt their email correspondence with their probation and parole counterparts. Moreover, the ANEW case managers utilize their own electronic health records (EHR) system.

TECHNICAL RELATIONSHIPS

In the context of ANEW, I find that case managers' service objectives blend with the technical terms and requirements of their clients' justice supervision. For instance, while shadowing Monique one afternoon at ATC, she tells me about a client she transported earlier in the day. Specifically, she drove the client from ATC to an Integral Care drop-in clinic across town so that the client could pick up some prescription medication and receive other acute psychiatric services. Monique says the client has not had any medication since moving to ATC. She waves her hands in circles as if she is conducting a magic trick, and says, "This woman can move things around. She sees demonic spirits. I don't think she is dangerous. I just know that she has been off her meds for six months." Monique tells me the client recently agreed to go to Integral Care's drop-in clinic in order to receive a full psychiatric evaluation. She says, "Hopefully, we can get her back on her meds."

As Monique is typing her notes in her office, a TDCJ parole officer (PO) knocks on her open door. The PO asks Monique about the client, who is also on his caseload, and wonders if the transportation to the clinic went well. Monique tells the PO, "I am just so thankful that you were able to talk her into going to the clinic." Monique conveys to the PO that the medication could have a big impact for this particular client moving forward, especially given client's severe auditory, visual, and olfactory delusions. The PO, who is still standing in the doorway, says, "Yea, I'm hopeful the meds will help too." He admits that he has different tactics that he can use when negotiating with his clients. Although he says he doesn't like to use the fact that his clients are on parole when negotiating with them, he says, "If I have to, I will tell them. I will remind them of where they are at – that they are on parole."

In a separate conversation at ANEW's main clinic, Barbara describes the dynamic between her own service objectives and the technical terms, requirements, of her clients' justice supervision. She tells me, "Technically, our services are voluntary, so the clients don't have to be here. But at the same time, they do. It's a weird relationship to have with your client." Barbara explains how she tries to talk her clients through these boundaries. In particular, she makes sure to inform the client about the consequences of not showing up for scheduled appointments. She says, "At the end of the day, I have to balance the needs of both sides. The POs have to run their supervision, and I'm here to serve the client."

Joe, who previously worked as a counselor at Integral Care's MCOT, suggests, "The MCOT clients have the right to be crazy, but the ANEW clients have less freedom. According to Joe, when the MCOT clients disengage from services, the counselors there cannot do much other than close out the case. At ANEW, however, Joe tells me there is a sense among the case managers that they must continue engaging with clients for longer periods of forced interaction. That is, the ANEW case managers feel like they must chase their 'no show' clients, or otherwise refer them back to the PO for violating the terms of the case management.

FINDING SHADES OF GREY

In an effort to balance this dynamic, the ANEW case managers work to validate their clients' trauma and extreme vulnerability. When talking with Paco at the main clinic, he tells me, "We have to find ways to incorporate harm reduction into our work. The legal system can be so black and white, but I try to find the shades of grey in this job." I ask Paco to give me an example, and he says, "Like, if a client discloses drug use. You know, I

usually let that slide. The clients have enough trouble separating us versus them as it is." Paco reference to 'them' is probation and parole, who would likely have a more technical reaction to a client's disclosure of drug use. In another example, Barbara informs me, "My nine o'clock appointment just no showed, but (the client) just got a full-time job. Obviously, I don't want to disrupt that, so I will need to reset boundaries with them." Technically, as a Transitional Case Manager, many of Barbara's clients have moderate risk levels, but she explains how she uses discretion when scheduling appointments with current clients, telling me, "If it is appropriate, I might even step them down early so they can complete the program."

The ANEW case managers often find a balanced approach by placing their clients' needs in context. Erin, who is an Intensive Case Manager at ANEW, recognizes that many of her clients are coming out of traumatic correctional environments. She even says that some have spent considerable time in isolation. Erin tells me that she tries to validate her clients' experiences by helping them make sense of it. For instance, she describes the importance of providing psychoeducation:

> When I am conducting a diagnosis review, I will ask the client for their input and feedback. We're all experts in our own lives, and it's important to give them a voice in their own experience with diagnosis. I don't want it to seem like I'm pushing it onto them or essentializing them as an ill person.

Barbara recognizes many of her clients' other vulnerabilities. For instance, with reference to housing insecurities, she says, "I have to tell my clients straight up, 'The situation you are in sucks.' Honestly, it's hard to address those issues." Having said that, she tells me that she always makes it a point to ask her clients about their physical needs. She says,

"Their physical needs are connected to their mental health needs, and there isn't a lot I can do until they get some those physical needs met." She also suggests it's a basic matter of respect, telling me, "It's just showing them some respect, because our clients really aren't getting a lot of that."

THE NEED TO FEED THE BEAST

Despite these adjustments to their service perspective, I find that other organizational pressures continue to limit the ANEW case managers' view of work-related success. Kelsey, who is a staff administrator at ANEW, explains the challenges of coordinating the referrals from probation and parole. In particular, she tells me that she struggles to coordinate the large volume of intake appointments. Kelsey says, "There are so many moving parts. It becomes hard to keep track of everything, and it's frustrating because I have this stack of referrals that is *this* thick." She points to the pile of files on her desk, and explains that – within the weekly batch of referrals – there are often expired referrals and duplicate referrals from probation and parole.

Scope Creep

Ginnette, who is the supervisor at ANEW, tells me about the key issues facing the case managers on staff. Specifically, she refers to a dynamic she calls, "Scope creep," and suggests the case managers are susceptible to a certain level of punitiveness based on the fact that their clients are on probation or parole. She tells me the case managers have to develop an appreciation for their clients' needs, and at the same time they have to develop an awareness of how the justice system operates. She says, "When I'm hiring, I look for candidates who can express the importance of staying in their own lane. The ANEW case

managers have to be detail oriented. We have to be clear and consistent because there is a lot of grey in our field that doesn't match what probation and parole are looking for." Ginnette gives an example of probation and parole officers asking ANEW case managers whether or not it's appropriate to remove a client from an ankle monitor. Ginnette tells me, "The ANEW case managers have to be able to say, 'That's not my job.'"

Lack of Success

The ANEW case managers often describe their own experiences with trauma exposure and burnout. Rick tells me, "You don't go into the field of mental health for the paycheck. Hearing about the trauma of your clients can weigh on you." He suggests that it can be particularly difficult to address homelessness among his clients, saying "It's like trying to sweep a flood with a broom." Paco also describes the challenge of addressing his clients' disadvantage, and says that he has trouble ensuring resources that are often unavailable. He tells me, "You can try to fix the system on a larger scale. But in the meantime, it would be great if you could just give me some more tools on the ground. The lack of success wears on me."

In a specific example of this dynamic, I observe Morgan debriefing a case with a TDCJ parole officer at ATC. The PO stops by Morgan's office shortly after she begins her morning shift. The PO leans through the doorway, and says, "Guess whose last day is today? They are letting (a client) out, and I'm giving her a bus pass." Morgan's mouth drops, and she seems shocked. Morgan later tells me that this particular client has been a resident at ATC for over a year. According to Morgan, the client spends most of her days underneath a blanket in the dorms. She doesn't shower as a barrier to protect herself from

the other residents, and she speaks to herself in multiple different voices. Morgan and the PO have a twenty-minute conversation about whether or not there is anything they can do for the client at this particular point. The PO says, "I'm going to give her a bus pass and a map to get to the Greyhound bus station, but I have no idea what's going to happen." The PO's goal is to get the client on a bus to Waco, TX, where there is a faith-based home that has agreed to house the woman for nine months. Morgan wonders out loud what it would even look like to put her on a bus. The PO tells Morgan, "I will call ahead to the organization up in Waco, just to give them a heads up that she should be up there within the next day or so." After the PO leaves, Morgan tells me that she wishes there was more she could do for the client, and describes the whole situation as, "Heartbreaking."

Screening Cycles

The ANEW case managers face significant pressure to manage the heavy caseloads upon referral from probation and parole. Although the routine assessments with current clients only last about thirty minutes, the intake assessments with new clients can last as long as two hours because of the basic issues that need to be introduced and reviewed. Paco tells me, "I only have time for one routine appointment per day, on top of the two or three intake appointments that I have scheduled. But I'm worried that if we keep this up, then it will just create a bottleneck for my caseload down the line." I ask Paco to describe the pressures of case management, and he tells me, "I'm trying to reconcile my clients' needs with the need to feed the beast." He points to the computer in his office, and says the ANEW case managers have twenty-four hours to complete their notes after an assessment.

He tells me that it's challenging to keep up with the appointments, conduct the assessments, and complete the notes in time.

During the end of my fieldwork at ANEW, I talk with Joe about the organizational pressures continuing to build. According to Joe, the ANEW program receives anywhere from one hundred to one hundred fifty new referrals every month. Just as Paco described, the ANEW case managers have to continually cycle through their intake appointments while at the same time meeting the needs of an ever-growing caseload. Given current staffing, however, Joe explains the caseloads recently became too much for the case managers to handle. As a result, the ANEW program had to change their assignment protocols upon referral. Whereas the case managers would typically conduct their full two-hour intake assessments with each new client, they now have to conduct a pre-screening assessment in order to prioritize ANEW's support services.

ANALYTICAL REVIEW

In this chapter, I describe how ANEW case managers provide mental health services to individuals on probation and parole. I find the ANEW case managers' service objectives often blend with the technical terms and requirements of their clients' justice supervision. In an effort to balance this dynamic for their clients, the ANEW case managers emphasize the, "Shades of grey," that various technicalities overlook. For instance, the ANEW case managers work to validate their clients' trauma and extreme vulnerability. Despite these adjustments to their service perspective, other organizational pressures continue to limit their view of work-related success. The ANEW case managers frame these sustained pressures as, "The need to feed the beast."

In my analysis of these findings, I suggest the ANEW case managers occupy a boundary role at the periphery of their focal organization (Steadman 1992). In particular, the ANEW case managers have to balance the function of their boundary role in order to conduct their primary occupational task of providing psychiatric case management to individuals on probation and role. As organizational boundary spanners, the ANEW case managers process external sources of information coming into their focal organization. For instance, the case managers filed referrals from their justice partners, and they work with the probation and parole officers to coordinate information pertaining to their clients' risk, needs, and receptivity assessments. The case managers also provide their clients with support by introducing and connecting them to new tools and available resources in the community.

The ANEW case managers' professional autonomy and decision-making capacity is connected to their primary occupational task of conducting mental health assessments of individuals on probation and parole. From that point, the ANEW case managers provide various support services to their clients and relay select information to their justice counterparts. However, as mental health boundary spanners, their professional prerogatives are susceptible to the external influences of the technical terms and requirements associated with the status of their clients. In response, I find the ANEW case managers decouple their service ideals from the various 'black and white' technicalities imposed by their justice partnerships (Lipsky 2010; Thornton et al. 2012). In doing so, the ANEW case managers place a heavy emphasis on addressing the 'shades of grey' within their clients' lives. That

is, the ANEW case managers develop a keen awareness of their clients' socioeconomic disadvantage and the importance of addressing needs beyond psychiatric care.

These organizational and occupational dynamics have collaborative and practical implications for the ANEW case managers in the re-entry setting. In particular, the case managers remain bound by various organizational pressures (Steadman et al. 2016). For instance, the ANEW counselors experience 'scope creep' stemming from their interactions with probational and parole officers (Bloche 1999). Moreover, they struggle with 'lack of success' among the populations they serve. Many of their clients are either 'no shows' or end up completing the program with nothing to really show for it (Fisher and Drake 2007; Lamb and Weinberger 2013). These additional organization pressures, combined with increased caseloads, create a heavy burden to manage the screening process and otherwise serve a people processing function in their role (Draine et al. 2007; Hasenfeld 1972).

Chapter 6: When Planting a Seed is the Ceiling

Mental health boundary spanners who provide direct services in various justice-oriented contexts reconcile the tensions between their occupational constraints and service ideals by conceptualizing their work as 'planting a seed' among the individuals they serve, particularly with the hope that a pattern of sustained engagement with other direct services will emerge. However, in my analysis of the ethnographic data across each of the research sites in this study, I suggest 'planting a seed' is the practical ceiling of these cross-system interventions. Instead of providing transformational mental health care that reduces justice involvement and recidivism, the mental health boundary spanners perceive the organizational and institutional function of their services in 'people processing' terms, shifting individuals when possible from one system to the other (Fisher and Drake 2007:547; Hasenfeld 1972). In the crisis outreach context, mental health boundary spanners are particularly frustrated with the lack of recourse available to individuals they serve. Similarly, in the jail setting, mental health boundary spanners struggle with the inevitability of harm caused by the environment in which they operate. And finally, in the context of community-based justice supervision, mental health boundary spanners describe the function of their work as, "Sweeping a flood with a broom."

RECAP AND REVIEW

Persons with serious mental illness (PSMI) are consistently over-represented in the criminal justice system (Bureau of Justice Statistics 2006; Steadman et al. 2009; Teplin 1990). In an effort to reduce justice involvement and recidivism among PSMI, criminal justice and mental health systems have developed numerous intervention-related policies

and practices that emphasize increased access to psychiatric treatment and diversion (Council of State Governments 2002; Lamb et al. 2004; Munetz and Griffin 2006). These intervention programs target multiple points of justice system processing, including pre-arrest diversion, post-arrest/pre-trial diversion, mental health courts, access to psychiatric treatment during incarceration, re-entry planning, and community-based support. In practice, however, these mental health services are often constrained by external influences and conflicting procedures between the two systems (Draine et al. 2007; Steadman 1992). These institutional and organizational constraints represent a direct threat to autonomy and decision-making powers of the mental health professionals who work in these settings (Draine et al. 2007; Steadman 1992). And yet, the current literature is not at all clear as to whether these mental health professionals attempt to reconcile the tensions in their work, or how these dynamics might otherwise influence their perception of the services they provide. As such, this research is principally motivated by the professional experience of providing mental health services in various justice-oriented contexts.

This research has four main conceptual threads. I begin with reference to the organizational literature, and conceptualize the mental health professionals who work in these settings as organizational boundary spanners (Aldrich and Herker 1977; Steadman 1992). I am particularly interested in exploring the occupational duties and professional autonomy of mental health boundary spanners. Next, I consider the work-related tensions that manifest for mental health boundary spanners, particularly as their service ideals conflict with various organizational constraints. Then, I borrow from institutional and organizational theory in order to explore the pressures of conflicting institutional logics

(Chiarello 2015; Thornton and Ocasio 2008) and the process of decoupling (Lipsky 2010; Meyer and Rowan 1977). Specifically, I examine mental health boundary spanners' attempts to reconcile the limitations to their service ideals. Finally, as mental health boundary spanners' work becomes increasingly entangled with justice-oriented objectives, I reflect on the collaborative implications of dual loyalty (Bloche 1999) and the practical implications of perceived liability and limited recourse (Scheid 2000).

The data for this project stem from a series of ethnographic observations with mental health professionals working in various justice-oriented contexts. In particular, this study focuses on mental health professionals who provide community-based crisis intervention services, jail-based mental health services, and community-based mental health services for adults on probation and parole. The three specific programs in this study are all located in Austin, Travis County (TX), and represent a range of justice-mental health interventions and service models in the area. The ethnographic data, consisting of extensive fieldnotes, capture the work-related experiences of the mental health professionals operating in their respective fields. The analyses explore the ethnographic data within the context of each site. I present core ethnographic scenes, shorter vignettes, and key quotes to illustrate the professional experience of providing mental health services in justice-oriented contexts. In addition to presenting the thematic findings, I also present an overarching research argument that considers the findings across all contexts.

In Chapter 3, I describe how jail counselors conduct routine mental health assessments and make subsequent housing recommendations to the correctional staff. I find there are specific disconnects between inmates' psychiatric needs and the limited services

that the jail counselors are able to provide. The jail counselors experience this disconnect as their patients, “Fall through the cracks,” but they reconcile these concerns by limiting their service expectations. In particular, they conceptualize, “Getting a win,” in terms directly associated with their service constraints. Despite the development of relatively sustainable work-related perspectives, the jail counselors continue to frame their professional experience as extremely isolating. Moreover, they express specific concerns of liability stemming from their housing decisions, and a general sense of unease with respect to the lack of recourse available to the inmates at the jail. In sum, they feel their work in the jail is situated in, “The worst of all worlds.”

In Chapter 4, I describe how EMCOT counselors engage with exclusive referrals for crisis intervention services. Despite their efforts to connect individuals experiencing psychiatric crisis to appropriate sources of care as soon as possible, I find the EMCOT counselors are often constrained by the voluntary nature of the services they provide. They perceive this limitation on their service objective as particularly frustrating, and recognize that it sets them up for, “Other problems down the road.” In response to the tensions associated with their clients’ voluntary service engagement, the EMCOT counselors reconceptualize their service ideals by viewing crisis intervention as a potential moment in which new patterns of client trust can emerge. However, I find that the EMCOT counselors are also required to manage the expectations of their community partners with rather limited resources. These tensions combine to produce a frequent sense of helplessness among the EMCOT counselors, who perceive their work as being situated, “In between two worlds.”

In Chapter 5, I describe how ANEW case managers provide mental health services to individuals on probation and parole. I find the ANEW case managers' service objectives often blend with the technical terms and requirements of their clients' justice supervision. In an effort to balance this dynamic for their clients, the ANEW case managers emphasize the, "Shades of grey," that various technicalities overlook. For instance, the ANEW case managers work to validate their clients' trauma and extreme vulnerability. Despite these adjustments to their service perspective, other organizational pressures continue to limit their view of work-related success. The ANEW case managers frame these sustained pressures as, "The need to feed the beast."

Mental health boundary spanners who provide direct services in various justice-oriented contexts reconcile the tensions between their occupational constraints and service ideals by conceptualizing their work as 'planting a seed' among the individuals they serve, particularly with the hope that a pattern of sustained engagement with other direct services will emerge. However, in my analysis of the ethnographic data across each of the research sites in this study, I suggest 'planting a seed' is the practical ceiling of these cross-system interventions. Instead of providing transformational mental health care that reduces justice involvement and recidivism, the mental health boundary spanners perceive the organizational and institutional function of their services in 'people processing' terms, shifting individuals when possible from one system to the other (Fisher and Drake 2007:547; Hasenfeld 1972).

ADDITIONAL ANALYSES

This project is motivated by the professional experience of providing connections to mental health care in the justice context. In an effort to frame this issue, I explore mental health professionals' conceptualization of certain 'institutional logics' (Thornton and Ocasio 2008). The institutional logics framework is useful when considering how mental health boundary spanners perceive the structural, normative, and symbolic dimensions of their work in the justice context. For instance, the prevalent 'logics' in mental health systems include individualized treatment and person-centered care (Council of State Governments 2002; Draine et al. 2007:170). On the other hand, the 'logics' of individual accountability, public safety, and security are all traditionally associated with justice-oriented systems (Council of State Governments 2002; Draine, et al. 2007:170). In this project, I explore how the competing logics of 'safety' and 'care' influence the professional experience of providing mental health services in multiple justice-mental health contexts. Through my analysis of the ethnographic data, I find that 'safety as care' is a useful way to conceptualize or understand the occupational experiences associated with providing direct mental health services for justice-involved populations. Moreover, 'safety as care' reflects the changing function of the systems of care as they are subsumed by the criminal justice enterprise.

I find that various organizational-level dynamics shape the tensions associated with 'safety as care' in settings throughout the justice-mental health context (Steadman 1992:79). For instance, in the jail setting, the counselors operate within an existing framework of custodial and correctional design. That is, their professional duties are fundamentally linked to the correctional housing and security of inmates. The jail

counselors are inundated with pressures, concerns, and protocols that are not typically associated with other mental health services (Scheid 2000; Steadman 1992). To the extent that care is provided and prioritized in the jail, it is subsumed by correctional policies and other safety concerns. As such, the jail counselors are trying to keep the individuals in the custody of the jail as safe as possible through their mental health assessments and housing recommendations, and 'planting a seed' where they can.

This notion of 'safety as care' is not limited to the jails. In this study, the three research sites under review all have unique organizational structures that influence the programs, professionals, and delivery of care. By design, this approach provides an opportunity to explore how variations in organizational structure shape the work-related tensions associated with 'safety as care' (Steadman 1992:79). For instance, in the community-based settings of EMCOT and ANEW, 'safety as care' is reflected in the direct referrals that the counselors and case managers receive from their justice counterparts. When mental health services are placed in the context jail diversion and re-entry supervision, the front-line mental health boundary spanners have to adjust to the salient pressures of public safety and individual accountability in those settings.

In my analysis of the ethnographic data, I find a variety of mechanisms at the organizational level influence the extent to which 'safety as care' takes hold. One such mechanism is the professional status of the mental health boundaries spanners. Most, if not all, of the participants in this study are professionally licensed counselors. However, in terms of their status relative to other mental health professionals, such as psychiatrists, psychologists, and nurse practitioners, they have considerably less status. Across each of

the sites in this study, the mental health boundary spanners were susceptible to external influences on their own professional prerogative. For instance, the concerns of 'scope creep' among the ANEW case managers are not dissimilar to the dual loyalty concerns that jail counselors must also navigate. It is important to consider how the mental health boundary spanners' relatively low professional status influences these dynamics, even as many of their justice counterparts have less educational attainment and professional licensure. As such, 'safety as care' reflects the primacy of justice-oriented prerogatives in this context and the challenge of the mental health boundary spanners.

RESEARCH CONTRIBUTIONS

In this study, I suggest 'planting a seed' is the practical ceiling of various justice-mental health interventions, while 'people processing' is their norm. According to Hasenfeld, "People processing organizations are defined as attempting to achieve changes in their clients not by altering basic personal attributes, but by conferring on them a public status and relocating them in a new set of social circumstances" (1972:256). This study supports the view that justice-mental health intervention programs serve a 'people processing' function. As Fisher and Drake (2007:547) note:

> Historically, societal pressure to institutionalize persons with mental illness has been a constant. Only the names of the institutions change: almshouses, hospitals, "ships of fools," nursing homes, homeless shelters, jails. The modern temper, however, uniquely promotes medicalizing and criminalizing social problems… placing greater and greater pressures on overburdened mental health and criminal justice systems to control the tragic circumstances that society has created.

Although this research is not intended to be a program evaluation or quality improvement project, the findings nonetheless contribute to contemporary discussions that contextualize

the function and purpose of reform (Bell 2017; Brayne and Christin 2000; Engel et al. 2020; Wood et al. 2017).

Recent efforts to reform the criminal justice system have resulted in new practices in policing, prosecution, corrections, and other community supervision programs. For instance, police officers in Texas now receive additional training for crisis intervention (Sandra Bland Act 2017), and local prosecutors are being elected to public office on campaign platforms of wholesale justice reform (Hall 2020). Despite these changes and others, many scholars remain skeptical of the implications and overall consequences of procedural justice reform (Bell 2017). For instance, some scholars suggest such reforms actually serve to reinforce the legitimacy of the police and the power of the state (Engel et al. 2020; Gorz 1968). Similarly, other scholars find they entrench the production of inequality (Brayne and Christin 2020). This research sheds light on the recent proliferation of justice-mental health interventions and reform policies. The development of connections to mental health care is a noble – if not necessary – criminal justice reform (Fisher et al. 2006; Fisher and Drake 2007). However, as this research shows, such efforts may do more to change the provision of mental health care than the actual systems of justice processing.

FUTURE DIRECTIONS

This research is principally motivated by the professional experience of providing mental health services in various justice-oriented contexts. And yet, we know little about how the professional counterparts in the criminal justice system reconcile the increasing connectedness of their own work to the provision of mental health care. The issue comes up throughout my observations across each research site. For instance, while following the

EMCOT counselors, I have a one-on-one conversation with an APD law enforcement officer who approaches me and asks about my research. I tell the officer that I am interested in learning more about the connections between criminal justice and mental health systems, and he explains that he feels police are unfairly judged in their role. In particular, the officer cites the City Auditor's report, which finds a disproportionate use-of-force among police in response to mental health related calls (City of Austin 2018). The officer says to me, "That report was not fair at all." I explain to the officer that my research is not intended to be a program evaluation or quality improvement project, and starts to tell me more about the nature of his work and the role of modern police. As he describes, "Solving homelessness is a major issue here in Austin, but is that the job of police? I mean, if the city wants us to do animal control, then sure we can respond to dog fights."

Coded language aside, the example above underscores the notion that many of the research questions and conceptual frameworks that I present here can be similarly applied to the mental health boundary spanners' criminal justice counterparts. In one example of this approach, Wood and colleagues (2017) study police work during mental health encounters, and find that such responses occur in the "Gray Zone" of policing. In particular, they find that police work in response to mental health-related calls often relies on a temporary or provisional means of addressing issues of chronic vulnerability (Wood et al. 2017:15). Similarly, Engel and Silver (2001:226) argue that such encounters involve a great deal of police discretion. In particular, Engel and Silver suggest 'order maintenance' situations require more police discretion than 'law enforcement' situations, which are typically guided by strict legal statutes and administrative policies (Engel and Silver

2001:226). In addition to the perspectives and experiences of law enforcement officers, future research might also consider the view of prosecutors who operate in problem-solving courts, corrections officers who operate in the psychiatric units of prisons or jails, and probation and parole officers who operate with specialized mental health caseloads.

Appendices

APPENDIX A: CRIMINALITY VERSUS CRIMINALIZATION

In an attempt to explain the prevalence of mental illness in the justice system, most scholars point to one of two competing perspectives: criminality and criminalization. In this section, I review existing research evidence – both supporting and refuting each perspective[16].

Criminality

The criminality perspective is more of a publicly held belief that mental illness is associated with increased criminality, and that persons with serious mental illness are prone to violence and criminal offending (Link et al. 1999; Wahl 1997). In addition to public perceptions of dangerousness, the criminality perspective is reinforced by scholarly interpretations of certain prevalence rates. Proponents of the criminality perspective argue that the disproportionality of mental illness in the justice system is attributable to individual-level risk factors for offending and arrest among persons with serious mental illness (Engel and Silver 2001; Hirschfield et al. 2006; Torrey 1994). However, the evidence in support of criminality is far from unequivocal. For instance, according to meta-analytic research conducted by Bonta and colleagues (1998), the major predictors of recidivism (e.g. criminal history, antisocial personality, substance abuse, and family dysfunction) are the same for parolees/probationers with and without serious mental

[16] For additional review of this debate, see: Ballard and Teasdale 2016; Engel and Silver 2001; Hiday and Burns 2010; Hirschfield et al. 2006; Teplin 1983.

illness. Furthermore, research evidence does not generally support the notion that MDOs on parole/probation are more likely to return to prison for committing a new or violent offense (Feder 1991; Porporino and Motiuk 1995). These findings are contrary to the thesis of criminality and warrant consideration for other perspectives.

Criminalization

Over the past five decades, proponents of the criminalization perspective have used a more historical, system-level approach to dissect the disproportionate prevalence of serious mental illness in the criminal justice system. These analyses explore a precipitous era, beginning in the late 1960's, when states first changed their approach to psychiatric hospitalization by restricting the use of involuntary commitments (Appelbaum 1994; Durham and Pierce 1982). Deinstitutionalization efforts were meant to refine the legal rights of psychiatric patients in state mental hospitals and conform the mental health system to the principles of due process (Abramson 1972). For better or worse, however, the mental health deinstitutionalization era is now defined by three subsequent developments of this reform: (1) outpatient treatment options largely replaced hospitalized care, (2) individuals could more-easily refuse to engage in such treatment given the new legal context of patient rights, and (3) treatment became increasingly unavailable due to overall fiscal reductions within the mental health system (Teplin 1983:55; Teplin 1984:159).

As a result of deinstitutionalization, the number of individuals with serious mental illness living in the community grew larger than ever before (Whitmer 1980). Moreover, in terms of addressing deviant behavior exhibited by persons with serious mental illness, the deinstitutionalization movement effectively limited the recourse available to agents of

formal social control (Fisher et al. 2006:545; Lamb, Weinberger, and DeCuir 2002). The number of justice-involved individuals with serious mental illness sharply increased as the number of available hospital beds began to decline, and the criminal justice system began to supplant the mental health system as the major institution of social control (Liska et al. 1999; Markowitz 2011; Whitmer 1980).

Instead of attributing the disproportionality of mental illness in the justice system to individual-level factors of criminality, the criminalization perspective suggests that deinstitutionalization led to a re-labeling phenomenon whereby deviant behavior associated with persons with serious mental illness became defined in criminal rather than psychiatric terms (Ballard and Teasdale 2016; Fisher et al. 2006; Hiday and Burns 2010). Proponents of the criminalization perspective highlight research evidence pertaining to the specific mechanisms of justice involvement for persons with serious mental illness. For instance, researchers have found that high recidivism rates for MDOs are largely due to technical parole/probation violations (Abadinsky 2000; Eno Louden and Skeem 2013), which are perhaps related to the intense scrutiny of forensic treatment programs (Draine & Solomon 1994; Eno Louden and Skeem 2013). Likewise, Teplin (1984) argued that, as a result of deinstitutionalization and the increased prevalence of persons with serious mental illness living in the community, police informally changed the way they treat the behaviors associated with mental illness – which ultimately led to higher arrest rates among this population. In other words, the criminalization of mental illness is perceived as a side effect of deinstitutionalization, where justice-oriented correction facilities became the default site

of social control in the trending absence of mental health resources (Abramson 1972; Fisher et al. 2006; Lamb et al. 2004; Whitmer 1980).

However, a growing body of evidence suggests the criminalization hypothesis does not fully account for the link between mental illness and crime. For instance, contrary to Teplin's (1984) findings, more recent evidence suggests police do not over-arrest persons with serious mental illness controlling for encounter-level factors (Engel and Silver 2001). Other researchers have poked holes in the criminalization perspective by arguing that instead of mental illness being criminalized per se, punitive policies associated with the U.S. prison boom account for increased rates of justice involvement for individuals both with and without serious mental illness, and that post-deinstitutionalization increases in criminal justice involvement are not unique to persons with serious mental illness (Ballard and Teasdale 2016; Frank and Glied 2006). Likewise, researchers have found that increases in local mental health resources and services do not impact the prevalence of MDOs in nearby jails (Fisher et al. 2000).

APPENDIX B: THE ROLE OF PSYCHIATRIC TREATMENT IN CONTEXT

In an effort to address the issue of justice involvement among persons with serious mental illness, criminal justice reform advocates have presented various policy recommendations over the course of the past two decades. For instance, many researchers and advocates endorse strong institutional collaboration between mental health and criminal justice systems (Binwanger et al. 2011; Council of State Governments 2002; Haimowitz 2002; Lamb and Weinberger 1998; Lamb et al. 2002; Lamb et al. 2004; Munetz and Griffin 2006; Osher et al. 2003; Steadman et al. 2009; Wolff 1998). Many of these

recommendations are based on the underlying assumption that regular access to treatment – and in particular a consistent course of psychiatric medication as a means to control symptomology – reduces justice involvement for MDOs (Baillargeon et al. 2009:108; Casey et al. 2013:177; Davis, Sheidow, and McCart 2014; Lamb et al. 2004; Lamb and Weinberger 2013). The policies and practices associated with this logic are part of a broad "treatment paradigm" in which mental health treatment and diversion are viewed as the panacea for criminal offending among persons with serious mental illness (Bonta et al. 1998:123; Draine et al. 2007:161; Fisher et al. 2006:548; Hiday and Wales 2011:82; Skeem et al. 2014:212).

Emerging evidence, however, suggests the relationship between mental illness and justice involvement is generally mediated by other risk factors strongly associated with crime (Barrenger and Draine 2013; Bonta et al. 1998; Draine et al. 2002; Silver 2006; Skeem et al. 2011). In other words, very few MDOs engage in criminal behavior as a direct result of their mental health status (Hiday and Burns 2010; Hiday and Wales 2011; Junginger et al. 2006; Silver 2006; Skeem et al. 2011:119). This notion seriously limits the standard appeal of the treatment paradigm. Specifically, if mental illness is only indirectly causative of justice involvement, then effective desistance programming requires more than psychiatric treatment and symptom reduction.

Mental Illness and Criminal Behavior

Scholars are beginning to embrace multiple criminological-informed frameworks for understanding criminal behavior among MDOs (Bonta et al. 1998; Draine et al. 2005; Fisher et al. 2006; Fisher and Drake 2007; Silver 2006; Skeem et al. 2011). For instance,

Silver (2006) engages with various criminological theories of violence – including social learning, social stress, social control, rational choice, and social disorganization theories – and underscores the combination of clinical and criminological risk factors that might lead to violent behavior among persons with serious mental illness. Similarly, Fisher and colleagues (2006) highlight three separate criminological theories – including the life course perspective, the local life circumstances perspective, and the routine activities perspective – and describe how each might contribute to our better understanding of criminal offending among persons with severe mental illness.

Virginia Hiday and colleagues present another useful framework, in which they introduce a typology of the relationship between mental illness and criminal offending by delineating the role of the various criminogenic needs[17] specific to this population (Hiday 1999; Hiday and Burns 2010; Hiday and Wales 2011; Hiday and Wales 2013). In total, Hiday and colleagues reference five distinct groups of MDOs, each based on the dominant risk factors that lead to offending, arrest, and incarceration (Hiday and Burns 2010:497; Hiday and Wales 2011:90; Hiday and Wales 2013:575).

The five groups consist of the "No-Place-To-Go Group", the "Survival Group", the "Substance Abuse Group", the "Criminal Thinking Group", and the "Illness Only Group"

[17] Criminogenic needs are typically defined as "Dynamic risk factors that when changed are associated with changes in recidivism (Bonta et al. 1998:138). Such needs include attitudes and cognitions, social relationships with peers and family, as well as activities and lifestyle (Andrews et al. 1990; Andrews and Bonta 1998; Bonta et al. 1998). Importantly, mental illness and psychological distress are not criminogenic needs for the vast majority of MDOs (Bonta et al. 1998:138; Skeem et al. 2011:119-21).

(Hiday and Burns 2010; Hiday and Wales 2011; Hiday and Wales 2013). The first two groups – the "No-Place-To-Go Group" and the "Survival Group" – are the largest and consist of individuals who commit only misdemeanor crimes (Hiday and Burns 2010). For instance, individuals in the "No-Place-To-Go Group" are typically arrested for minor public nuisances such as loitering, while individuals in the "Survival Group" tend to commit criminal offenses such as shoplifting to obtain food or trespassing to obtain shelter (Hiday and Burns 2010; Hiday and Wales 2013). Notably, individuals in both groups experience severe economic and social disadvantage. Referring to the "No-Place-To-Go Group," Hiday and Wales (2013) explain, "Their (nuisance) behavior would not be cause for arrest if they did not occur in public" (2013:575). Likewise, in reference to the "Survival Group," Hiday and Burns (2010) explain, "This group violates the law and becomes criminal not because mental illness forces them to do so but rather because both their social background and mental illness leave them poor, marginal, often homeless, and without the necessary care and services they need to survive in the community" (2010:497).

Similar to individuals in the first two groups, individuals in the "Substance Abuse Group" experience social and economic marginalization. However, in addition to nuisance and survival crimes, individuals in the "Substance Abuse Group" are arrested for various behaviors connected to supporting their alcohol and illicit drug addictions (Hiday and Burns 2010; Hiday and Wales 2013). With the exception of their substance misuse as a form of self-medication, their mental illness is an underlying cause rather than a proximate cause of their criminal offending in most cases (Hiday and Wales 2011; Hiday and Wales 2013).

The fourth group of MDOs – the "Criminal Thinking Group" – consists of individuals whose criminal offending is a result of their learned antisocial behavior (Hiday and Wales 2011). Although a large proportion of all incarcerated individuals (including those without mental illness) have antisocial tendencies, mental illness among the "Criminal Thinking Group" seems to be coincidental to their justice involvement (Hiday and Wales 2011; Hiday and Wales 2013). In other words, the criminal and violent behavior among this group of MDOs is primarily driven by their antisocial tendencies and not their mental illness (Hiday and Burns 2010; Hiday and Wales 2013).

Finally, the "Illness Only Group" is the smallest of the five groups and consists of individuals with serious mental illness who engage in delusional violence (Hiday and Wales 2013; Junginger et al. 2006). Unlike the "Criminal Thinking Group," mental illness among those in the "Illness Only Group" causes individuals to assault others and is primary in their offending behavior. To be sure, delusional violence is rare, and the vast majority of individuals who experience delusions and hallucinations as a result of their psychosis do not engage in violent or otherwise criminal behavior (Junginger et al. 2006; Skeem et al. 2011).

Expanding Frameworks Beyond Treatment

The typology presented above illustrates the notion that MDOs are not a homogenous population, particularly with respect to the underlying causes of offending behavior. As Hiday and Wales (2011) state, "Severe mental illness itself, without other factors, does not seem to lead to offending in most cases" (2011:90). Considering this view, Skeem and colleagues (2011) posit, "Effective psychiatric treatment would reduce (justice

involvement) for the small group of offenders for whom serious mental illness has a direct effect on criminal behavior. It is less likely that such treatment would reduce (justice involvement) for the remaining groups of MDOs, where the effect of mental illness is fully mediated by general risk factors" (2011:119)[18]. Hiday's typology is thus useful as a means to contextualize both the need for treatment and the importance of targeting stronger risk factors for crime among MDOs (Barrenger and Draine 2013; Bonta et al.1998:138; Draine et al. 2002; Hiday and Wales 2013; Skeem et al. 2001:121).

As with non-mentally disordered populations, the primary factors associated with promoting and maintaining desistance[19] among MDOs are related to the informal social control mechanisms associated with housing, social support, and employment stability (Barrenger and Canada 2014; Draine et al. 2005; Fisher and Drake 2007; Göbbels, Thakker, and Ward 2016:81; Taxman, Young, and Byrne 2004; Thompson 2008; Wolff and Draine 2004). In other words, the process of desistance may not be parallel to, or even reliant upon, the successful treatment of symptomology (Barrenger and Canada 2014; Bonta et al. 1998:135; Göbbels et al. 2016:75; Morrissey, Meyer, and Cuddeback 2007:531). This is not to suggest that psychiatric treatment for MDOs is futile, or that

[18] "From a criminological perspective, even if mental illness contributed to downward socioeconomic drift, it is unlikely that symptom improvement will reverse poverty or associated criminogenic factors that are more socioeconomic than medical" (Skeem et al. 2011:120).

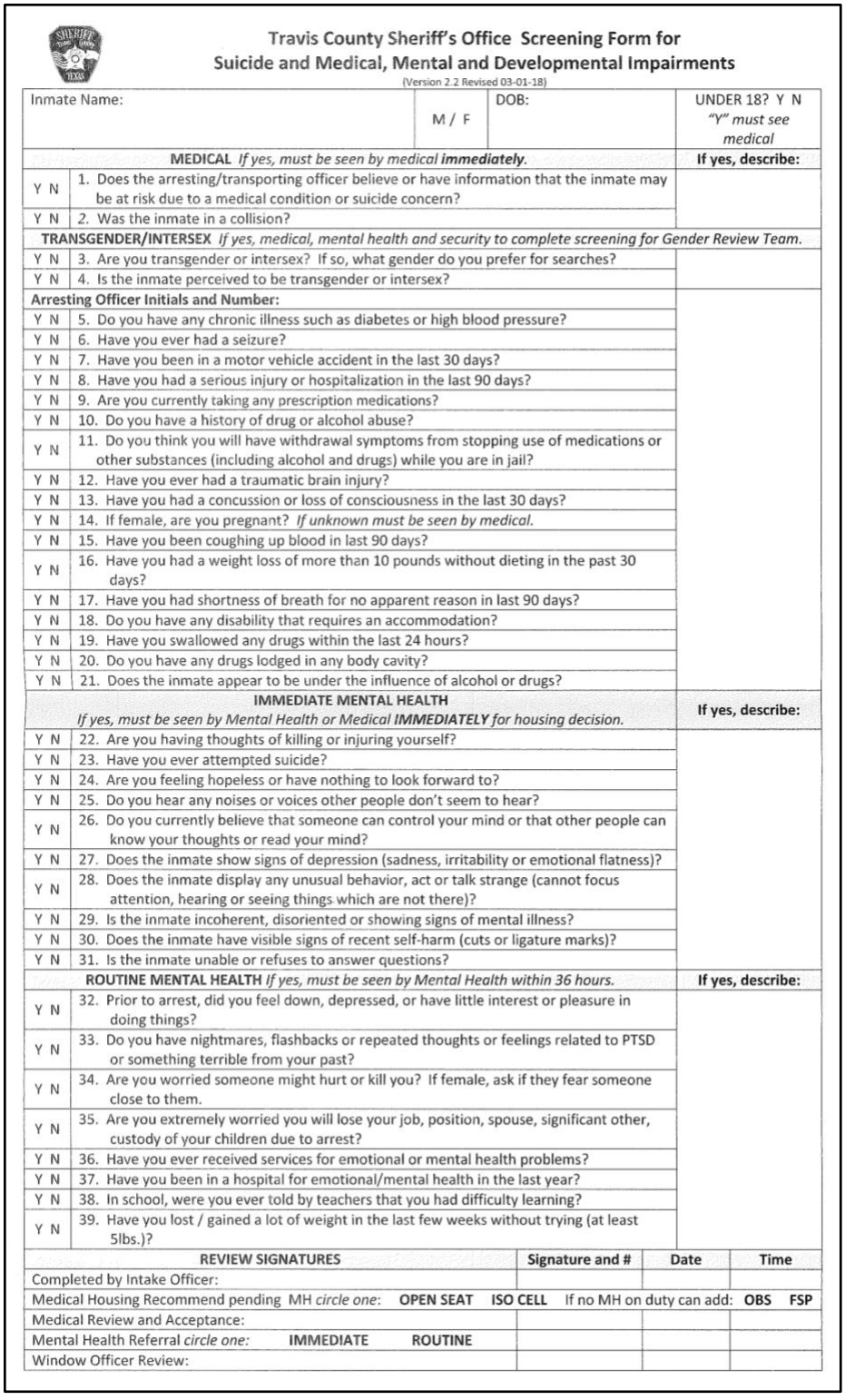
[19] Criminology literature defines desistance as, "The process that maintains a continued state of non-offending" (Laub and Sampson 2001:11). For further review of the general theories of desistance, see: Laub and Sampson 2001; Maruna, Immarigeon, and LaBel 2004; McNeill 2006; Porporino 2010; Uggen 2000.

mental health and criminal justice collaborations are unimportant[20]. Instead, these frameworks suggest collaborative intervention strategies with a core emphasis on psychopathology are insufficient as a means to actually reduce criminal offending for the vast majority of MDOs because the principal role of socioeconomic disadvantage is marginalized in the process (Barrenger and Canada 2014; Draine et al. 2002; Fisher et al. 2006; Fisher and Drake 2007; Hiday and Burns 2010; Hiday and Wales 2011; Silver 2006; Steadman et al. 2016). These alternative perspectives invite a renewed discussion of desistance programming for MDOs.

APPENDIX C: TCSO INTAKE ASSESSMENT FORM

TCSO deputies at the intake desk complete an initial assessment of all inmates during the primary custody exchange with the arresting officer. This initial assessment is based on the TCSO Intake Assessment Form, which has three unique sections with a total of thirty-nine questions. For reference, see Figure C.1 below. The first twenty-one questions are specific to the inmates' immediate medical needs. In the second section of the TCSO intake Assessment Form, there are ten questions are all related to the inmates' *immediate* psychiatric needs. In the third section of the TCSO Intake Assessment Form, there are eight questions all related to the inmates' *routine* mental health needs.

[20] Indeed, some scholars have recently theorized that desistance among MDOs operates through a unique combination of individual-level and structural-level factors (Göbbels et al. 2016:77; Morrissey et al. 2007:531). Individual-level factors may include "readiness" and "receptivity" toward cognitive and behavioral rehabilitation. In some cases, these factors are supported by successful psychiatric treatment (Göbbels et al. 2016).



Travis County Sheriff's Office Screening Form for Suicide and Medical, Mental and Developmental Impairments

(Version 2.2 Revised 03-01-18)

Inmate Name:	M / F	DOB:	UNDER 18? Y N *"Y" must see medical*

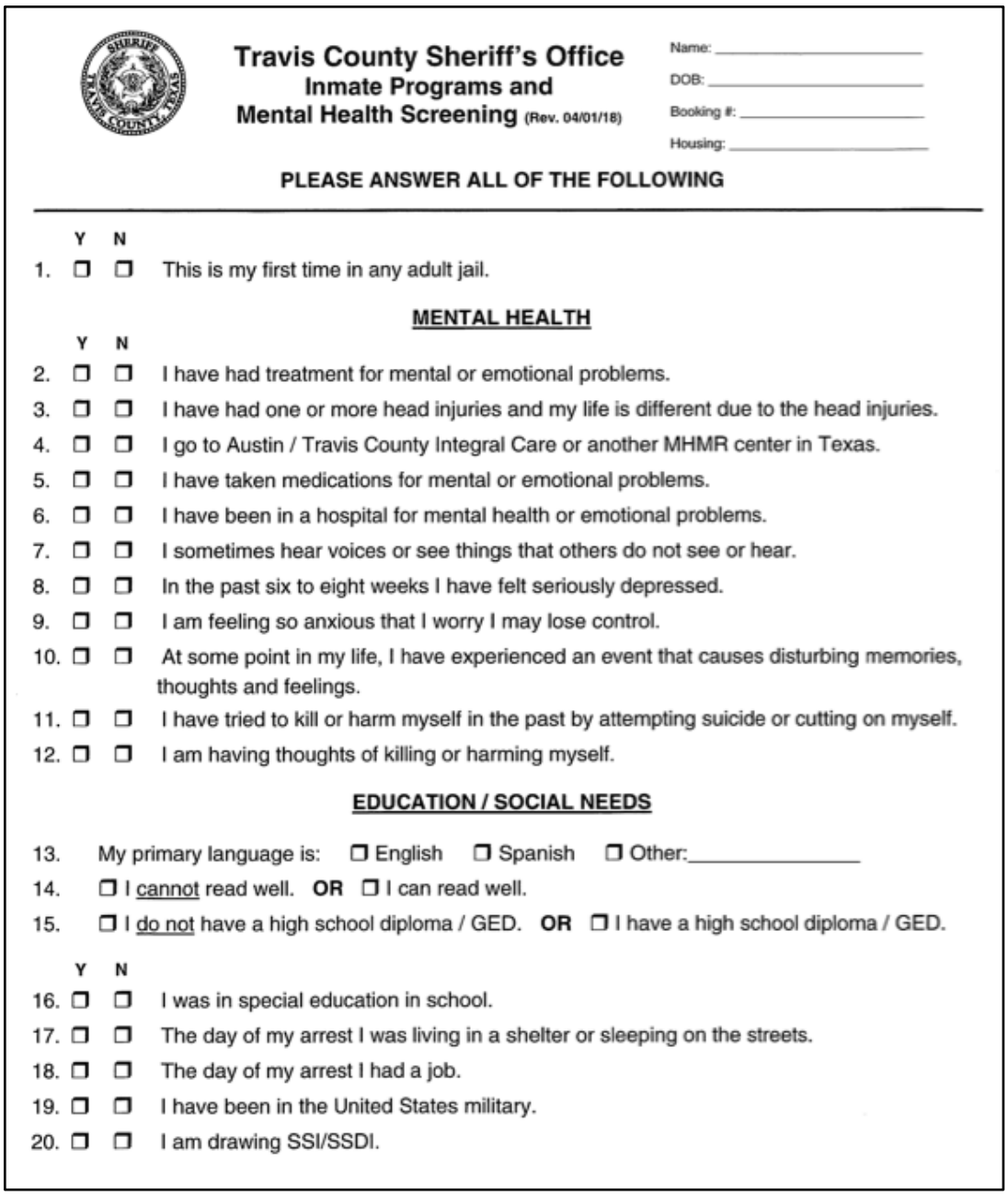
	MEDICAL *If yes, must be seen by medical* ***immediately***.	**If yes, describe:**
Y N	1. Does the arresting/transporting officer believe or have information that the inmate may be at risk due to a medical condition or suicide concern?	
Y N	2. Was the inmate in a collision?	
	TRANSGENDER/INTERSEX *If yes, medical, mental health and security to complete screening for Gender Review Team.*	
Y N	3. Are you transgender or intersex? If so, what gender do you prefer for searches?	
Y N	4. Is the inmate perceived to be transgender or intersex?	
	Arresting Officer Initials and Number:	
Y N	5. Do you have any chronic illness such as diabetes or high blood pressure?	
Y N	6. Have you ever had a seizure?	
Y N	7. Have you been in a motor vehicle accident in the last 30 days?	
Y N	8. Have you had a serious injury or hospitalization in the last 90 days?	
Y N	9. Are you currently taking any prescription medications?	
Y N	10. Do you have a history of drug or alcohol abuse?	
Y N	11. Do you think you will have withdrawal symptoms from stopping use of medications or other substances (including alcohol and drugs) while you are in jail?	
Y N	12. Have you ever had a traumatic brain injury?	
Y N	13. Have you had a concussion or loss of consciousness in the last 30 days?	
Y N	14. If female, are you pregnant? *If unknown must be seen by medical.*	
Y N	15. Have you been coughing up blood in last 90 days?	
Y N	16. Have you had a weight loss of more than 10 pounds without dieting in the past 30 days?	
Y N	17. Have you had shortness of breath for no apparent reason in last 90 days?	
Y N	18. Do you have any disability that requires an accommodation?	
Y N	19. Have you swallowed any drugs within the last 24 hours?	
Y N	20. Do you have any drugs lodged in any body cavity?	
Y N	21. Does the inmate appear to be under the influence of alcohol or drugs?	
	IMMEDIATE MENTAL HEALTH *If yes, must be seen by Mental Health or Medical* ***IMMEDIATELY*** *for housing decision.*	**If yes, describe:**
Y N	22. Are you having thoughts of killing or injuring yourself?	
Y N	23. Have you ever attempted suicide?	
Y N	24. Are you feeling hopeless or have nothing to look forward to?	
Y N	25. Do you hear any noises or voices other people don't seem to hear?	
Y N	26. Do you currently believe that someone can control your mind or that other people can know your thoughts or read your mind?	
Y N	27. Does the inmate show signs of depression (sadness, irritability or emotional flatness)?	
Y N	28. Does the inmate display any unusual behavior, act or talk strange (cannot focus attention, hearing or seeing things which are not there)?	
Y N	29. Is the inmate incoherent, disoriented or showing signs of mental illness?	
Y N	30. Does the inmate have visible signs of recent self-harm (cuts or ligature marks)?	
Y N	31. Is the inmate unable or refuses to answer questions?	
	ROUTINE MENTAL HEALTH *If yes, must be seen by Mental Health within 36 hours.*	**If yes, describe:**
Y N	32. Prior to arrest, did you feel down, depressed, or have little interest or pleasure in doing things?	
Y N	33. Do you have nightmares, flashbacks or repeated thoughts or feelings related to PTSD or something terrible from your past?	
Y N	34. Are you worried someone might hurt or kill you? If female, ask if they fear someone close to them.	
Y N	35. Are you extremely worried you will lose your job, position, spouse, significant other, custody of your children due to arrest?	
Y N	36. Have you ever received services for emotional or mental health problems?	
Y N	37. Have you been in a hospital for emotional/mental health in the last year?	
Y N	38. In school, were you ever told by teachers that you had difficulty learning?	
Y N	39. Have you lost / gained a lot of weight in the last few weeks without trying (at least 5lbs.)?	

REVIEW SIGNATURES	**Signature and #**	**Date**	**Time**
Completed by Intake Officer:			
Medical Housing Recommend pending MH *circle one*: **OPEN SEAT** **ISO CELL** If no MH on duty can add: **OBS** **FSP**			
Medical Review and Acceptance:			
Mental Health Referral *circle one:* **IMMEDIATE** **ROUTINE**			
Window Officer Review:			

Figure C.1: Photocopy of the TCSO Intake Assessment Form.

APPENDIX D: TCSO MENTAL HEALTH SCREENING FORM

In addition to the immediate and routine psychiatric assessments in Central Booking, the jail counselors are also required to conduct a separate, follow-up assessment for *all* inmates who are booked into the jail. The follow-up assessments are called, "Counselor's Initial Follow-up Review," or CIFR. The jail counselors base their CIFRs on the TCSO Mental Health Screening Form, which primarily screens for information related to inmates' mental health and substance use needs. For reference, see Figure D.1 below. The TCSO Classification Department (Class) requires the CIFRs to be completed prior to transferring the inmates from Central Booking to the Travis County Correctional Complex (TCCC). As such, the inmates who do not receive a mental health flag during their initial intake assessment will nonetheless need to be assessed as 'defaults' by the jail counselors. In practice, the CIFRs mostly serve an extra safety precaution to ensure that inmates' psychiatric presentations have not deteriorated since their intake assessment.



Travis County Sheriff's Office
Inmate Programs and
Mental Health Screening (Rev. 04/01/18)

Name: _____
DOB: _____
Booking #: _____
Housing: _____

PLEASE ANSWER ALL OF THE FOLLOWING

	Y	N	
1.	❒	❒	This is my first time in any adult jail.

MENTAL HEALTH

	Y	N	
2.	❒	❒	I have had treatment for mental or emotional problems.
3.	❒	❒	I have had one or more head injuries and my life is different due to the head injuries.
4.	❒	❒	I go to Austin / Travis County Integral Care or another MHMR center in Texas.
5.	❒	❒	I have taken medications for mental or emotional problems.
6.	❒	❒	I have been in a hospital for mental health or emotional problems.
7.	❒	❒	I sometimes hear voices or see things that others do not see or hear.
8.	❒	❒	In the past six to eight weeks I have felt seriously depressed.
9.	❒	❒	I am feeling so anxious that I worry I may lose control.
10.	❒	❒	At some point in my life, I have experienced an event that causes disturbing memories, thoughts and feelings.
11.	❒	❒	I have tried to kill or harm myself in the past by attempting suicide or cutting on myself.
12.	❒	❒	I am having thoughts of killing or harming myself.

EDUCATION / SOCIAL NEEDS

13. My primary language is: ❒ English ❒ Spanish ❒ Other:_____
14. ❒ I cannot read well. **OR** ❒ I can read well.
15. ❒ I do not have a high school diploma / GED. **OR** ❒ I have a high school diploma / GED.

	Y	N	
16.	❒	❒	I was in special education in school.
17.	❒	❒	The day of my arrest I was living in a shelter or sleeping on the streets.
18.	❒	❒	The day of my arrest I had a job.
19.	❒	❒	I have been in the United States military.
20.	❒	❒	I am drawing SSI/SSDI.

Figure D.1: Photocopy of the TCSO Mental Health Screening Form.

SUBSTANCE USE

21. Within the last year, I have used the following substances, including pills not prescribed to me. Check all that apply:

- ❒ Alcohol – beer, wine, liquor
- ❒ Cannabis - marijuana (weed), hashish (hash)
- ❒ Sedatives/Hypnotics - bars, benzos,downers, sleeping pills, tranks, roofies, Xanax
- ❒ Hallucinogens - ecstasy, MDMA, shrooms, ketamine, salvia, LSD, DMT, peyote, PCP
- ❒ Opioids - heroin, opium, prescription pain relievers (hydrocodone, Oxycontin)
- ❒ Stimulants - cocaine, meth, khat
- ❒ Inhalants - gases, aerosols, chemicals
- ❒ Other - GHB, steroids, K2, bath salts, kush, crocodile and those not listed
- ❒ None - I have not used any substances, alcohol or pills not prescribed to me in the last year.

	Y	N	
22.	❒	❒	Did you use larger amounts of drugs or use them for longer than you planned or intended?
23.	❒	❒	Did you try to control or cut down on your drug use but were unable to do so?
24.	❒	❒	Did you spend a lot of time getting drugs, using them, or recovering from their use?
25.	❒	❒	Did you have a strong desire or urge to use drugs?
26.	❒	❒	Did you get so high or sick from using drugs that it kept you from working, going to school or caring for your children?
27.	❒	❒	Did you continue using drugs even when it led to social or interpersonal problems?
28.	❒	❒	Did you spend less time at work, school, or with friends because of your drug use?
29.	❒	❒	Did you use drugs that put you or others in physical danger?
30.	❒	❒	Did you continue using drugs even when it was causing you physical or psychological problems?
31.	❒	❒	Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?
32.	❒	❒	Did using the same amount of a drug lead to it having less of an effect as it did before?
33.	❒	❒	Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?
34.	❒	❒	Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?

35. How serious do you think your substance problems are?
    Not at all ❒ Slight ❒ Moderate ❒ Considerable ❒ Extreme ❒
36. How important is it for you to get substance abuse treatment now?
    Not at all ❒ Slight ❒ Moderate ❒ Considerable ❒ Extreme ❒
37. Do you want information, education or group support regarding substance use?
    Yes ❒ No ❒

Inmate Signature:_____ Date:_____

Figure D.1, cont.: Photocopy of the TCSO Mental Health Screening Form.

APPENDIX E: MENTAL HEALTH RESOURCES

I would like to encourage you, as the reader, to invest in your mental health by connecting with the appropriate services to support your own long-term mental wellness. If, however, you – or someone you know – experience a mental health crisis, please consider engaging with the resources that I have listed below.

'Crisis Text Line': Correspond with a trained crisis counselor through a secure and confidential platform. Text "NAMI" or "HOME" to 741741 from anywhere in the United States. International services are also available. For more information, visit: https://www.crisistextline.org/ (Crisis Text Line 2020).

'Mobile Crisis Outreach': Receive face-to-face from mental health professionals at your home, office, school, or other location. Contact your local mental health authority for more information. In Austin, Travis County (TX), call 512-472-4357. For more information, visit: https://integralcare.org/program/mobile-crisis-outreach-team-mcot/ (Integral Care 2020b).

'National Suicide Prevention Lifeline': Connect with free and confidential emotional support if you, or someone you know, is in suicidal crisis or emotional distress. Call 1-800-273-8255. For more information, visit: https://suicidepreventionlifeline.org/ (National Suicide Prevention Lifeline 2020).

Glossary

Many of the key terms used throughout this project carry specific connotations and stigmas (Link et al. 1999; Vingilis and State 2011:14). In an effort to be mindful of this terminology, I have compiled a list of common phrases used across psychiatric and criminal justice literatures and note the contexts in which they are used (Council of State Governments 2002:11; Covell et al. 2007; McGuire-Snieckus, McCabe, Priebe 2003).

'Client': Mental health professionals use the term 'client' in an acknowledgment that the individuals they are serving have some expertise in their own experience and what course of action is best for them. Accordingly, caring for clients reflects, "A more consumer or collaborative type of relationship characterized by a relatively non-hierarchical form of interaction" (McGuire-Snieckus et al. 2003). For distinction with other terms, such as, 'Patient,' see reference below.

'Justice Involvement': A common term used to reference some connection to the criminal justice system. Specific levels of involvement may reference a variety of related experiences, including arrest, probation, incarceration, parole, re-arrest, and other statuses or experiences related to being involved in the criminal justice system.

'Mentally Disordered Offender' (MDO): A common term used in reference to justice-involved individuals with serious mental illness. Most literature refers to individuals who have committed a criminal offense as "criminal offenders." The 'offender' status holds a particularly negative connotation, in part because of some harm done to someone or something. While not all criminal offenses have a victim in the strict sense of the term, and many MDOs become justice-involved for victimless crimes, criminal

behavior itself is socially constructed and the legal definition of a crime involves its nature as a public wrong. These issues have clear implications related to the historical and contemporary responses to mental illness, including both formal and informal social controls. Furthermore, in terms of 'disorder' status, we must be aware of the social stigmas and self-stigmas related to the experience of living with a medically diagnosed illness or disorder. These stigmas often have very real and negative effects, including isolation and social distance from even the most intimate or personal social connections (Link et al. 1999; Vingilis and State 2011:14).

'Patient': Mental health professionals use the term 'patient' in reference to, "A medical relationship that emphasizes the authority of the professional and the relative passivity of the patient" (McGuire-Snieckus et al. 2003). The use of 'patient' implies the need to use professional expertise in order diagnose an individual, or provide them with a particular course of treatment or care.

'Serious Mental Illness' (SMI): The Substance Abuse and Mental Health Services Administration (SAMHSA) defines serious mental illness as, "Having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illnesses include major depression, schizophrenia, and bipolar disorder, and other mental disorders that cause serious impairment" (Substance Abuse and Mental Health Services Administration 2017). Refer to Section 2 of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 2013) for more information on the diagnostic categories of serious mental illness. It is important to note

the spectrum and variety of serious mental illnesses, as well as the fact that the vast majority of all persons with serious mental illness (PSMI) are not justice-involved.

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